

LYRICA[®]

PREGABALIN

SUMMARY PRODUCT

Classification

Analgesic Agent

Route of Administration	Dosage Form / Strength	Clinically Relevant Nonmedicinal Ingredients
Oral	Capsules, 25 mg, 50 mg, 75 mg, 150 mg, 300 mg	Lactose monohydrate For a complete listing, see Dosage Forms, Composition and Packaging section.

INDICATIONS AND CLINICAL USE

Adults: LYRICA (pregabalin) is indicated for the management of neuropathic pain associated with:

- Diabetic peripheral neuropathy and
- Postherpetic neuralgia

Geriatrics (>65 years of age): Pregabalin oral clearance tended to decrease with increasing age. This decrease in pregabalin oral clearance is consistent with age-related decreases in creatinine clearance. Reduction of pregabalin dose may be required in patients who have age-related compromised renal function. (See **WARNINGS AND PRECAUTIONS**, Geriatrics >65 years of age)

Pediatrics (<18 years of age): The safety and efficacy of pregabalin in pediatric patients (<18 years of age) have not been established and its use in this patient population is not recommended (see **WARNINGS AND PRECAUTIONS**, Pediatrics).

CONTRAINDICATIONS

Patients who are hypersensitive to pregabalin or to any ingredient in the formulation or component of the container.

WARNINGS AND PRECAUTIONS

Tumorigenic Potential

In standard preclinical *in vivo* lifetime carcinogenicity studies of pregabalin, a high incidence of hemangiosarcoma was identified in two different strains of mice (see **Preclinical Toxicology**). The clinical significance of this finding is uncertain. Clinical experience during pregabalin's premarketing development provides no direct means to assess its potential for inducing tumors in humans.

In clinical studies across various patient populations, comprising 6396 patient-years of exposure in 8666 patients ranging in age from 12 to 100 years, new or worsening pre-existing tumors were reported in 57 patients. The most common malignant tumor diagnosed was skin carcinoma (17 patients) followed by breast carcinoma (8 patients), prostatic carcinoma (6 patients), carcinoma not otherwise specified (6 patients) and bladder carcinoma (4 patients). Without knowledge of the background incidence and recurrence in similar populations not treated with LYRICA (pregabalin), it is impossible to know whether the incidence seen in these cohorts is or is not affected by treatment.

Ophthalmological Effects

In controlled studies, pregabalin treatment was associated with vision-related adverse events such as blurred vision (amblyopia) [6% pregabalin and 2% placebo] and diplopia (2% pregabalin and 0.5% placebo). Approximately 1% of pregabalin-treated patients discontinued treatment due to vision-related adverse events (primarily blurred vision). Of the patients who did not withdraw, the blurred vision resolved with continued dosing in approximately half of the cases (see **Post-Marketing Adverse Drug Reactions**).

Prospectively planned ophthalmologic testing, including visual acuity testing, formal visual field testing and dilated fundoscopic examination, was performed in over 3600 patients. In these patients, visual acuity was reduced in 7% of patients treated with pregabalin, and 5% of placebo-treated patients. Visual field changes were detected in 13% of pregabalin-treated, and 12% of placebo-treated patients. Fundoscopic changes were observed in 2% of pregabalin-treated, and 2% of placebo-treated patients. At this time, clinical significance of the ophthalmologic findings is unknown.

Patients should be informed that if changes in vision occur, they should notify their physician. If visual disturbance persists, further assessment, including discontinuation of pregabalin, should be considered. More frequent assessments should be considered for patients who are already routinely monitored for ocular conditions.

Peripheral Edema

In controlled clinical trials pregabalin treatment caused peripheral edema in 6% of patients (336/5508) compared with 2% of patients (42/2384) in the placebo group. In these studies, 0.5% (28/5508) of pregabalin patients and 0.2% (4/2384) of placebo patients withdrew due to peripheral edema (see **ADVERSE REACTIONS**, Peripheral Edema).

In controlled clinical trials of up to 13 weeks in duration of patients without clinically significant heart or peripheral vascular disease, there was no apparent association between peripheral edema and cardiovascular complications such as hypertension or congestive heart failure. In the same trials, peripheral edema was not associated with laboratory changes suggestive of deterioration in renal or hepatic function.

Higher frequencies of weight gain and peripheral edema were observed in patients taking both LYRICA (pregabalin) and a thiazolidinedione antidiabetic agent compared to patients taking either drug alone. The majority of patients using thiazolidinedione antidiabetic agents in the overall safety database were participants in studies of pain associated with diabetic peripheral neuropathy. In this population, peripheral edema was reported in 3% (2/60) of patients who were using thiazolidinedione antidiabetic agents only, 8% (69/859) of patients who were treated with pregabalin only, and 19% (23/120) of patients who were on both pregabalin and thiazolidinedione antidiabetic agents. Similarly, weight gain was reported in 0% (0/60) of patients on thiazolidinediones only, 4% (35/859) of patients on pregabalin only, and 7.5% (9/120) of patients on both drugs.

As the thiazolidinedione class of antidiabetic drugs can cause weight gain and/or fluid retention, possibly exacerbating or leading to heart failure, care should be taken when co-administering LYRICA and these agents.

Because there are limited data on congestive heart failure patients with New York Heart Association (NYHA) Class III or IV cardiac status, LYRICA should be used with caution in these patients.

Weight Gain

Pregabalin treatment was associated with weight gain. In pregabalin controlled clinical trials of up to 13 weeks, a gain of 7% or more over baseline weight was observed in 8% of pregabalin-treated patients and 2% of placebo-treated patients. Few patients treated with pregabalin (0.2%) withdrew from controlled trials due to weight gain (see **ADVERSE REACTIONS**, Weight Gain). Pregabalin associated weight gain was related to dose and duration of exposure, but did not appear to be associated with baseline BMI, gender or age. Weight gain was not limited to patients with edema (see **WARNINGS AND PRECAUTIONS**, Peripheral Edema).

Although weight gain was not associated with clinically important changes in blood pressure in short-term controlled studies, the long-term cardiovascular effects of pregabalin-associated weight gain are unknown.

Among diabetic patients, pregabalin-treated patients gained an average of 1.6 kg (range: -16 to 16 kg), compared to an average 0.3 kg (range: -10 to 9 kg) weight gain in placebo patients. In a cohort of 333 diabetic patients who received pregabalin for at least 2 years, the average weight gain was 5.2 kg.

While the effects of pregabalin-associated weight gain on glycemic control have not been systematically assessed, in controlled and longer-term open label clinical trials with diabetic patients, pregabalin treatment did not appear to be associated with loss of glycemic control (as measured by HbA_{1c}).

Dizziness and Somnolence

In controlled neuropathic pain studies, pregabalin caused dizziness in 23% of patients (424/1831) compared to 7% in placebo (58/857). Somnolence was experienced by 14% (256/1831) and 4% (33/857) of the patients treated with pregabalin and placebo, respectively. These events began shortly after the initiation of therapy and generally occur more frequently at higher doses. In these studies, dizziness and somnolence led to withdrawal of 3.5% and 2.6% of the pregabalin-treated patients, respectively. For the remaining patients (359 and 208, respectively) who experienced these events, dizziness and somnolence persisted until the last dose of pregabalin in 43% and 58% of the patients, respectively (see **ADVERSE REACTIONS**, Tables 2 and 4, and **Post-Marketing Adverse Drug Reactions**).

Accordingly, patients should be advised not to drive or operate complex machinery or engage in other hazardous activities until they have gained sufficient experience on pregabalin to gauge whether or not it affects their mental and/or motor performance adversely (see **CONSUMER INFORMATION**).

Abrupt or Rapid Discontinuation

Following abrupt or rapid discontinuation of pregabalin, some patients reported symptoms including insomnia, nausea, headache and diarrhea. Pregabalin should be tapered gradually over a minimum of one week rather than discontinued abruptly (see **ADVERSE REACTIONS**, Adverse Events Following Abrupt or Rapid Discontinuation).

Sexual Function/Reproduction

Impairment of Male Fertility

Preclinical Data

In fertility studies in which male rats were orally administered pregabalin (50 to 2500 mg/kg) prior to and during mating with untreated females, a number of adverse reproductive and developmental effects were observed. These included decreased sperm counts and sperm motility, increased sperm abnormalities, reduced fertility, increased preimplantation embryo loss, decreased litter size, decreased fetal body weights and an increased incidence of fetal abnormalities. Effects on sperm and fertility parameters were reversible in studies of this duration (3-4 months). The no-effect dose for male reproductive toxicity in these studies (100 mg/kg) was associated with a plasma pregabalin exposure (AUC) approximately 3 times human exposure at the maximum recommended dose (MRD) of 600 mg/day.

In addition, adverse effects on reproductive organ (testes, epididymides) histopathology were observed in male rats exposed to pregabalin (500 to 1250 mg/kg) in general toxicology studies of four weeks or greater duration. The no-effect dose for male reproductive organ histopathology in rats (250 mg/kg) was associated with a plasma exposure approximately 8 times human exposure at the MRD.

In a fertility study in which female rats were given pregabalin (500, 1250 or 2500 mg/kg) orally prior to and during mating and early gestation, disrupted estrous cyclicity and an increased number of days to mating were seen at all doses and embryolethality occurred at the highest dose. The low dose in this study produced a plasma exposure approximately 9 times that in humans receiving the MRD. A no-effect dose for female reproductive toxicity in rats was not established. The clinical significance of female fertility findings in animals is unknown.

Human Data

In a double-blind, placebo-controlled clinical trial to assess the effect of pregabalin on sperm motility, 30 healthy male subjects were exposed to pregabalin 600 mg/day for 3 months (one complete sperm cycle). Pregabalin did not exhibit significant detrimental effects on the reproductive function of healthy male subjects, as measured by semen analysis, when compared with placebo (n=16). However, due to the small sample size and short-term exposure to pregabalin (only one complete sperm cycle), no conclusions can be made regarding possible reproductive effects of pregabalin during long-term exposure. Effects on other male reproductive parameters in humans have not been adequately studied.

Special Populations

Renal

Because pregabalin is eliminated primarily by renal excretion, the dose of pregabalin should be adjusted as noted for elderly patients with renal impairment (see **ACTION AND CLINICAL PHARMACOLOGY** and **DOSE AND ADMINISTRATION**).

Adjustment of Dose in Renally-Impaired Patients

In patients with a medical history of significant renal insufficiency, daily dosages should be reduced accordingly (see Table in **DOSE AND ADMINISTRATION**, **Dosing Considerations**).

Preclinical Data

Pregabalin was not teratogenic in mice, rats or rabbits. Pregabalin induced fetal toxicity in mice and rabbits at ≥ 3 times the mean human exposure at the maximum recommended clinical dose of 600 mg/day [AUC₀₋₂₄ of 123 $\mu\text{g}\cdot\text{hr}/\text{mL}$]. In the prenatal-postnatal toxicity study, pregabalin induced offspring developmental toxicity in rats at ≥ 5 times the maximum recommended human exposure. No developmental effects occurred at 2 times the maximum recommended human exposure (see **PRODUCT MONOGRAPH**).

Human Data

Pregnant Women

There are no adequate and well-controlled studies in pregnant women. Pregabalin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labour and Delivery

The effects of pregabalin on labour and delivery in pregnant women are unknown. In the prenatal-postnatal study in rats, pregabalin prolonged gestation and induced dystocia at exposures ≥ 47 times the mean human exposure [AUC₀₋₂₄ of 123 $\mu\text{g}\cdot\text{hr}/\text{mL}$] at the maximum recommended clinical dose of 600 mg/day (see **PRODUCT MONOGRAPH**).

Nursing Women

It is not known if pregabalin is excreted in human breast milk; however, it is present in the milk of rats. Because of the potential for adverse reactions in nursing infants from pregabalin, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother (see **PRODUCT MONOGRAPH**).

Pediatrics (<18 years of age)

The safety and efficacy of pregabalin in pediatric patients (<18 years of age) have not been established.

Geriatrics (>65 years of age)

Of the 1831 patients who received pregabalin in neuropathic pain studies, 528 were 65 to 74 years of age, and 452 were 75 years of age or older. No significant differences in efficacy were observed between these patients and younger patients. Pregabalin oral clearance tended to decrease with increasing age. This decrease in pregabalin oral clearance is consistent with age-related decreases in creatinine

clearance. Reduction of pregabalin dose may be required in patients who have age-related compromised renal function. In general, the incidence of adverse events did not increase with age.

Crete Kinase Elevations

Pregabalin treatment was associated with creatine kinase elevations. Mean changes in creatine kinase from baseline to the maximum value were 60 U/L for pregabalin-treated patients and 28 U/L for the placebo patients. In all controlled trials across multiple patient populations, 2% of patients on pregabalin and 1% of placebo patients had a value of creatine kinase at least three times the upper limit of normal. Three pregabalin-treated subjects had events reported as rhabdomyolysis in premarketing clinical trials. The relationship between these myopathy events and pregabalin is not completely understood because the cases had documented factors that may have caused or contributed to these events. Prescribers should instruct patients to promptly report unexplained muscle pain, tenderness or weakness, particularly if these muscle symptoms are accompanied by malaise or fever. Pregabalin treatment should be discontinued if myopathy is diagnosed or suspected or if markedly elevated creatine kinase levels occur.

Laboratory Changes, Decreased Platelet Count

Pregabalin treatment was associated with a decrease in platelet count. Pregabalin-treated subjects experienced a mean maximal decrease in platelet count of 20 x 10³/ μL , compared to 11 x 10³/ μL in placebo patients. In the overall database of controlled trials, 2% of placebo patients and 3% of pregabalin patients experienced a potentially clinically significant decrease in platelets, defined as 20% below baseline value and <150 x 10³/ μL .

In randomized controlled trials, pregabalin was not associated with an increase in bleeding related adverse events.

ECG Changes, PR Interval Prolongation

Pregabalin treatment was associated with mild PR interval prolongation. In analyses of clinical trial ECG data, the mean PR interval increase was 3-6 msec at pregabalin doses ≥ 300 mg/day. This mean change difference was not associated with an increased risk of PR increase $\geq 25\%$ from baseline, an increased percentage of subjects with on-treatment PR >200 msec, or an increased risk of adverse events of second or third degree AV block.

Information for Patients

Dizziness and Somnolence

Patients should be counseled that LYRICA (pregabalin) may cause dizziness, somnolence, blurred vision and other CNS signs and symptoms. Accordingly, they should be advised not to drive, operate complex machinery or engage in other hazardous activities until they have gained sufficient experience on pregabalin to gauge whether or not it affects their mental, visual and/or motor performance adversely.

Visual Disturbances

Patients should be counseled that LYRICA may cause visual disturbances. Patients should be informed that if changes in vision occur, they should notify their physician (see **WARNINGS AND PRECAUTIONS**, Ophthalmologic Effects).

Abrupt or Rapid Discontinuation

Patients should be advised to take LYRICA as prescribed. Abrupt or rapid discontinuation may result in insomnia, nausea, headache or diarrhea.

Edema and Weight Gain

Patients should be counseled that LYRICA may cause edema and weight gain.

Patients should be advised that concomitant treatment with LYRICA and a thiazolidinedione antidiabetic agent may lead to an additive effect on edema and weight gain. For patients with preexisting cardiac conditions, this may increase the risk of heart failure.

Muscle Pain, Tenderness or Weakness

Patients should be instructed to promptly report unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Concomitant Treatment with CNS Depressants, Alcohol

Patients who require concomitant treatment with central nervous system depressants such as opiates or benzodiazepines should be informed that they may experience additive CNS side effects, such as somnolence.

Patients should be told to avoid consuming alcohol while taking LYRICA, as LYRICA may potentiate the impairment of motor skills and sedation of alcohol.

Pregnant Women

Patients should be instructed to notify their physician if they become pregnant or intend to become pregnant during therapy, and to notify their physician if they are breast-feeding or intend to breast-feed during therapy.

Animal Studies in Male Reproduction

In preclinical studies in rats, pregabalin was associated with an increased risk of male-mediated teratogenicity (see **WARNINGS AND PRECAUTIONS**, Sexual Function/Reproduction). The clinical significance of this finding is uncertain; however, men being treated with LYRICA who plan to father a child should be informed of the potential risk of male-mediated teratogenicity.

Skin

Diabetic patients should be instructed to pay particular attention to skin integrity while being treated with LYRICA. Some animals treated with pregabalin developed skin ulcerations, although no increased incidence of skin lesions associated with LYRICA was observed in clinical trials (see **PRODUCT MONOGRAPH**).

Patients should be informed of the availability of a patient information leaflet, and they should be instructed to read the leaflet prior to taking LYRICA.

Preclinical Toxicology

Carcinogenesis

A dose-dependent increase in the incidence of malignant vascular tumors (hemangiosarcomas) was observed in two strains of mice (B6C3F1 and CD-1) given pregabalin (200, 1000 or 5000 mg/kg) in the diet for two years. Plasma pregabalin exposure (AUC) in mice receiving the lowest dose that increased hemangiosarcomas was approximately equal to the human exposure at the maximum recommended dose (MRD) of 600 mg/day. A no-effect dose for induction of hemangiosarcomas in mice was not established. In an investigative study in female B6C3F1 mice, chronic treatment (24 months) with pregabalin at 1000 mg/kg caused an increased incidence of hemangiosarcoma, consistent with previous studies, but not at 50 or 200 mg/kg. Discontinuation of treatment after 12 months at 1000 mg/kg did not significantly reduce the incidence of hemangiosarcoma at 24 months. Evidence of carcinogenicity was not seen in two studies in Wistar rats following dietary administration of pregabalin for two years at doses (50, 150 or 450 mg/kg in males and 100, 300 or 900 mg/kg in females) that were associated with plasma exposures in males and females up to approximately 14 and 24 times, respectively, human exposure at the MRD. The clinical significance in humans of this finding in mice is unknown.

Mutagenesis

Pregabalin is not genotoxic based on results of a battery of *in vitro* and *in vivo* tests. Pregabalin was not mutagenic in bacteria or in mammalian cells *in vitro*, was not clastogenic in mammalian systems *in vitro* and *in vivo*, and did not induce unscheduled DNA synthesis in mouse or rat hepatocytes.

Dermatopathy

Skin lesions ranging from erythema to necrosis were seen in repeated-dose toxicology studies in both rats and monkeys. The etiology of these skin lesions is unknown. At the maximum recommended human dose (MRD) of 600 mg/day, there is a 2-fold safety margin for the dermatological lesions. The more severe dermatopathies involving

necrosis were associated with pregabalin exposures (as expressed by plasma AUCs) of approximately 3 to 8 times those achieved in humans given the MRD. No increase in incidence of skin lesions was observed in clinical studies.

Ocular lesions

Ocular lesions (characterized by retinal atrophy [including loss of photoreceptor cells] and/or corneal inflammation/mineralization) were observed in two lifetime carcinogenicity studies in Wistar rats. These findings were observed at plasma pregabalin exposures (AUC) ≥ 2 times those achieved in humans given the maximum recommended dose of 600 mg/day. A no-effect dose for ocular lesions was not established. Similar lesions were not observed in lifetime carcinogenicity studies in two strains of mice or in monkeys treated for 1 year. The clinical significance of this finding in rats is unknown.

Monitoring and Laboratory Tests

Routine therapeutic drug monitoring or clinical laboratory testing is not required for patients treated with LYRICA (pregabalin) (see **ADVERSE REACTIONS**).

ADVERSE REACTIONS

Adverse Drug Reaction Overview

Clinical Trial Adverse Drug Reactions

In all controlled and uncontrolled trials, more than 8666 patients have received LYRICA (pregabalin), with 83% of exposure at dosages of 300 mg/day or above and 32% at dosages of 600 mg/day or higher. Approximately 4010 patients had at least 6 months of exposure, 2415 had at least 1 year of exposure, and 939 had at least 2 years of exposure to pregabalin. In controlled trials, 1831 patients with neuropathic pain received pregabalin.

Most Common Adverse Events in All Controlled Clinical Studies of Neuropathic Pain

The most commonly observed adverse events ($\geq 5\%$ and twice the rate of that seen in placebo) in pregabalin-treated patients were: dizziness, somnolence, peripheral edema and dry mouth. Adverse events were usually mild to moderate in intensity.

Discontinuation Due to Adverse Events

In all controlled studies, the discontinuation rate due to adverse events was 14% for patients receiving pregabalin and 7% for patients receiving placebo. The most common reasons for discontinuation due to adverse events ($\geq 2\%$) in the pregabalin treatment groups were dizziness and somnolence. Other adverse events that led to withdrawal more frequently in the pregabalin group than the placebo group were ataxia (1%) and asthenia, confusion, headache and nausea (<1% each).

In controlled neuropathic pain studies, the discontinuation rate due to adverse events was 11% for pregabalin and 5% for placebo. The most common reasons for discontinuation due to adverse events ($\geq 2\%$) in the pregabalin treatment groups were dizziness and somnolence. Other adverse events that led to withdrawal more frequently in the pregabalin group than the placebo group were confusion (1%) and asthenia, peripheral edema and ataxia (<1% each).

Incidence of Adverse Events in Controlled Clinical Studies of Neuropathic Pain

In summaries of adverse events, investigator's terms for individual adverse events have been grouped into a smaller number of standardized categories using the COSTART IV dictionary. The prescriber should be aware that the percentages in Table 1 through Table 6 cannot be used to predict the frequency of adverse events in the course of usual medical practice where patient characteristics and other factors may differ from those prevailing during clinical studies. Similarly, the cited frequencies cannot be directly compared with figures obtained from other clinical investigations involving different treatments, uses or investigators. An inspection of these frequencies, however, does provide the prescriber with one basis to estimate the relative contribution of drug and non-drug factors to the adverse event incidences in the population studied.

Adverse Events From Controlled Clinical Studies of Neuropathic Pain Diabetic Peripheral Neuropathy

Table 1 lists all adverse events, regardless of causality, occurring in $\geq 2\%$ of patients with neuropathic pain associated with diabetic peripheral neuropathy receiving pregabalin for at least one of the pregabalin groups, and for which the incidence was greater than in the placebo group. A majority of pregabalin-treated patients in these studies had adverse events with a maximum intensity of mild or moderate. In these studies, 979 patients received pregabalin and 459 patients received placebo for up to 13 weeks.

Table 1. Incidence (%) of Treatment-Emergent Adverse Events in Placebo-Controlled Studies in Neuropathic Pain Associated with Diabetic Peripheral Neuropathy (Events in at Least 2% of Patients Receiving Pregabalin and More Frequent Than in Placebo-Treated Patients)

Body System Preferred Term	Pregabalin (mg/day)				
	Placebo (n = 459) %	75 (n = 77) %	150 (n = 212) %	300 (n = 321) %	600 (n = 369) %
Body as a whole					
Infection	6.1	3.9	7.5	8.4	4.6
Asthenia	2.4	3.9	1.9	4.4	7.3
Pain	3.9	5.2	4.2	2.5	4.9
Accidental injury	2.8	5.2	2.4	2.2	5.7
Back pain	0.4	0.0	2.4	1.2	1.9
Chest pain	1.1	3.9	1.4	1.2	1.6
Face edema	0.4	0.0	0.9	0.9	2.2
Digestive system					
Dry mouth	1.1	2.6	1.9	4.7	6.5
Constipation	1.5	0.0	2.4	3.7	6.0
Diarrhea	4.8	5.2	2.8	1.9	3.0
Flatulence	1.3	2.6	0.0	2.2	2.7
Vomiting	1.5	1.3	0.9	2.2	1.1
Hemic and lymphatic system					
Echymosis	0.2	2.6	0.5	0.6	0.3
Metabolic and nutritional disorders					
Peripheral edema	2.4	3.9	6.1	9.3	12.5
Weight gain	0.4	0.0	4.2	3.7	6.2
Edema	0.0	0.0	1.9	4.0	1.9
Hypoglycemia	1.1	1.3	3.3	1.6	1.1
Nervous system					
Dizziness	4.6	7.8	9.0	23.1	29.0
Somnolence	2.6	3.9	6.1	13.1	16.3
Neuropathy	3.5	9.1	1.9	2.2	5.4
Ataxia	1.3	6.5	0.9	2.2	4.3
Vertigo	1.1	1.3	1.9	2.5	3.5
Confusion	0.7	0.0	1.4	2.2	3.3
Euphoria	0.0	0.0	0.5	3.4	1.6
Thinking abnormal ^a	0.0	1.3	0.0	0.9	3.0

Body System Preferred Term	Pregabalin (mg/day)				
	Placebo (n = 459) %	75 (n = 77) %	150 (n = 212) %	300 (n = 321) %	600 (n = 369) %
Abnormal gait	0.0	1.3	0.0	0.6	2.7
Reflexes decreased	1.7	3.9	0.5	1.2	1.4
Amnesia	0.2	2.6	0.9	0.0	2.2
Hypesthesia	0.7	2.6	0.0	0.0	0.8
Hyperalgesia	0.2	2.6	0.0	0.0	0.3
Respiratory system					
Dyspnea	0.7	2.6	0.0	1.9	1.9
Skin and appendages					
Pruritus	1.3	2.6	0.0	0.9	0.0
Special senses					
Blurred vision ^a	1.5	2.6	1.4	2.8	1.5
Conjunctivitis	0.2	2.6	1.4	0.6	0.3

a Thinking abnormal primarily consists of events related to difficulty with concentration/attention but also includes events related to cognition and language problems and slow thinking.
b Investigator term; summary level term is amblyopia.

Discontinuation in Controlled Clinical Studies of Diabetic Peripheral Neuropathy

Approximately 9% of patients receiving pregabalin and 4% receiving placebo discontinued from controlled diabetic peripheral neuropathy studies due to adverse events. The adverse events most commonly leading to discontinuation are presented in Table 2.

Table 2. Adverse Events Most Frequently ($\geq 2\%$ of patients) Leading to Discontinuation in Placebo-Controlled Studies in Patients with Neuropathic Pain Associated with Diabetic Peripheral Neuropathy

COSTART Preferred Term	Number (%) of Patients				
	Placebo (n = 459)	75 (n = 77)	150 (n = 212)	300 (n = 321)	600 (n = 369)
Dizziness	2 (0.4)	0 (0.0)	3 (1.4)	6 (1.9)	21 (5.7)
Somnolence	0 (0.0)	0 (0.0)	0 (0.0)	5 (1.6)	15 (4.1)

Postherpetic Neuralgia

Table 3 lists all adverse events, regardless of causality, occurring in $\geq 2\%$ of patients with neuropathic pain associated with postherpetic neuralgia receiving pregabalin for at least one of the pregabalin groups, and for which the incidence was greater than in the placebo group. A majority of pregabalin-treated patients in these studies had adverse events with a maximum intensity of mild or moderate. In these studies, 852 patients received pregabalin and 398 patients received placebo for up to 13 weeks.

Table 3. Incidence (%) of Treatment-Emergent Adverse Events in Placebo-Controlled Studies in Neuropathic Pain Associated with Postherpetic Neuralgia (Events in at Least 2% of Patients Receiving Pregabalin and More Frequent Than in Placebo-Treated Patients)

Body System Preferred Term	Pregabalin (mg/day)				
	Placebo (n = 398) %	75 (n = 84) %	150 (n = 302) %	300 (n = 312) %	600 (n = 154) %
Body as a whole					
Infection	3.5	14.3	8.3	6.4	2.6
Headache	5.3	4.8	8.9	4.5	8.4
Pain	3.8	4.8	4.3	5.4	4.5
Asthenia	4.0	3.6	5.0	2.6	5.2
Accidental injury	1.5	3.6	2.6	3.2	5.2
Flu syndrome	1.3	1.2	1.7	2.2	1.3
Face edema	0.8	0.0	1.7	1.3	3.2
Malaise	1.0	2.4	0.3	0.6	0.0
Cardiovascular system					
Vasodilatation	1.3	2.4	1.0	0.6	0.0
Digestive system					
Dry mouth	2.8	7.1	7.0	6.1	14.9
Constipation	2.3	3.6	4.6	5.4	5.2
Diarrhea	4.0	2.4	4.3	3.5	4.5
Flatulence	1.0	2.4	1.3	1.6	3.2
Vomiting	0.8	1.2	0.7	2.9	2.6
Metabolic and nutritional disorders					
Peripheral edema	3.5	0.0	7.9	15.7	16.2
Weight gain	0.3	1.2	1.7	5.4	6.5
Edema	1.3	0.0	1.0	2.2	5.8
Hyperglycemia	0.8	2.4	0.3	0.0	0.0
Nervous system					
Dizziness	9.3	10.7	17.9	31.4	37.0
Somnolence	5.3	8.3	12.3	17.9	24.7
Ataxia	0.5	1.2	2.0	5.4	9.1
Abnormal gait	0.5	0.0	2.0	3.8	7.8
Confusion	0.3	1.2	2.3	2.9	6.5
Thinking abnormal ^a	1.5	0.0	1.7	1.3	5.8
Incoordination	0.0	2.4	1.7	1.3	2.6
Amnesia	0.0	0.0	1.0	1.3	3.9
Speech disorder	0.0	0.0	0.3	1.3	3.2
Insomnia	1.8	0.0	0.7	2.2	0.0
Euphoria	0.0	2.4	0.0	1.3	1.3
Nervousness	0.5	0.0	1.0	0.3	2.6
Tremor	1.5	1.2	0.0	1.0	2.6
Hallucinations	0.0	0.0	0.3	0.3	3.2
Hyperesthesia	0.3	2.4	0.3	0.0	1.3
Respiratory system					
Bronchitis	0.8	0.0	1.3	1.0	2.6
Pharyngitis	0.8	0.0	2.6	0.6	0.6

a Investigator term; summary level term is amblyopia.

Body System Preferred Term	Pregabalin (mg/day)				
	Placebo (n = 398) %	75 (n = 84) %	150 (n = 302) %	300 (n = 312) %	600 (n = 154) %
Rhinitis	1.8	1.2	0.7	0.6	3.2
Skin and appendages					
Rash	3.0	2.4	2.0	2.9	5.2
Special senses					
Blurred vision ^a	2.5	1.2	5.0	5.1	9.1
Diplopia	0.0	0.0	1.7	1.9	3.9
Abnormal vision	0.3	0.0	1.0	1.6	5.2
Urogenital system					
Urinary tract infection	1.5	0.0	2.3	1.6	3.2

a Thinking abnormal primarily consists of events related to difficulty with concentration/attention but also includes events related to cognition and language problems and slow thinking.
b Investigator term; summary level term is amblyopia.

Discontinuation in Controlled Clinical Studies of Postherpetic Neuralgia
Approximately 14% of patients receiving pregabalin and 7% receiving placebo discontinued from controlled postherpetic neuralgia studies due to adverse events. The adverse events most commonly leading to discontinuation are presented in Table 4.

Table 4. Adverse Events Most Frequently ($\geq 2\%$ of patients) Leading to Discontinuation in Placebo-Controlled Studies in Patients with Neuropathic Pain Associated with Postherpetic Neuralgia

COSTART Preferred Term	Number (%) of Patients				
	Placebo (n = 398)	75 (n = 84)	150 (n = 302)	300 (n = 312)	600 (n = 154)
Dizziness	3 (0.8)	0 (0.0)	11 (3.6)	12 (3.8)	12 (7.8)
Somnolence	1 (0.3)	0 (0.0)	6 (2.0)	12 (3.8)	10 (6.5)
Confusion	1 (0.3)	0 (0.0)	2 (0.7)	5 (1.6)	8 (5.2)
Peripheral edema	1 (0.3)	0 (0.0)	2 (0.7)	5 (1.6)	5 (3.2)
Ataxia	0 (0.0)	0 (0.0)	1 (0.3)	5 (1.6)	4 (2.6)
Abnormal gait	0 (0.0)	0 (0.0)	0 (0.0)	4 (1.3)	4 (2.6)
Hallucinations	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.3)	4 (2.6)
Dry mouth	1 (0.3)	0 (0.0)	0 (0.0)	0 (0.0)	4 (2.6)

Incidence of Most Common Dose-Related Treatment-Emergent Adverse Events

Most common dose-related treatment-emergent adverse events are presented in Table 5 (diabetic peripheral neuropathy) and Table 6 (postherpetic neuralgia).

Table 5. Incidence (%) of Most Common Dose-Related Treatment-Emergent Adverse Events in Placebo-Controlled Studies in Neuropathic Pain Associated with Diabetic Peripheral Neuropathy

Adverse Event Preferred Term	Pregabalin (mg/day)				
	Placebo (n = 459) %	75 (n = 77) %	150 (n = 212) %	300 (n = 321) %	600 (n = 369) %
Dizziness	4.6	7.8	9.0	23.1	29.0
Somnolence	2.6	3.9	6.1	13.1	16.3
Peripheral edema	2.4	3.9	6.1	9.3	12.5
Asthenia	2.4	3.9	1.9	4.4	7.3
Dry mouth	1.1	2.6	1.9	4.7	6.5
Weight gain	0.4	0.0	4.2	3.7	6.2
Constipation	1.5	0.0	2.4	3.7	6.0
Blurred vision ^a	1.5	2.6	1.4	2.8	5.7

a Investigator term; summary level term is amblyopia.

Table 6. Incidence (%) of Most Common Dose-Related Treatment-Emergent Adverse Events in Placebo-Controlled Studies in Neuropathic Pain Associated with Postherpetic Neuralgia

Adverse Event Preferred Term	Pregabalin (mg/day)				
	Placebo (n = 398) %	75 (n = 84) %	150 (n = 302) %	300 (n = 312) %	600 (n = 154) %
Dizziness	9.3	10.7	17.9	31.4	37.0
Somnolence	5.3	8.3	12.3	17.9	24.7
Peripheral edema	3.5	0.0	7.9	15.7	16.2
Dry mouth	2.8	7.1	7.0	6.1	14.9
Blurred vision ^a	2.5	1.2	5.0	5.1	9.1
Ataxia	0.5	1.2	2.0	5.4	9.1
Weight gain	0.3	1.2	1.7	5.4	6.5
Abnormal gait	0.5	0.0	2.0	3.8	7.8

a Investigator term; summary level term is amblyopia.

Adverse Events Following Abrupt or Rapid Discontinuation

Following abrupt or rapid discontinuation of pregabalin, some patients reported symptoms including insomnia, nausea, headache and diarrhea. Pregabalin should be tapered gradually over a minimum of one week rather than discontinued abruptly (see **WARNINGS AND PRECAUTIONS, Abrupt or Rapid Discontinuation**).

Drug Abuse and Dependence/Liability

In a study of recreational users (n=15) of sedative/hypnotic drugs, including alcohol, a single dose of LYRICA (pregabalin) 450 mg received subjective ratings of "good drug effect", "high", and "liking" to a degree that was similar to a single dose of diazepam 30 mg. In controlled clinical studies in over 5500 patients, 4% of LYRICA-treated patients and 1% of placebo-treated patients overall reported euphoria as an adverse event. However, in clinical trials of diabetic peripheral neuropathy, euphoria was reported as an adverse event by 1.8% of LYRICA-treated patients and 0% of placebo-treated patients, and in clinical trials of postherpetic neuralgia, euphoria was reported as an adverse event by 0.9% of LYRICA-treated patients and 0% of placebo-treated patients. In clinical studies, following abrupt or rapid discontinuation of pregabalin, some patients reported symptoms including insomnia, nausea, headache or diarrhea suggestive of physical dependence (see **WARNINGS AND PRECAUTIONS, Abrupt or Rapid Discontinuation**).

Pregabalin is not known to be active at receptor sites associated with drugs of abuse. As with any CNS active drug, physicians should carefully evaluate patients for history of drug abuse and observe them for signs of LYRICA misuse or abuse (e.g., development of tolerance, dose escalation, drug-seeking behaviour).

Other Events Observed During the Premarketing Evaluation of LYRICA

Following is a list of treatment-emergent adverse events reported during premarketing assessment of LYRICA in clinical trials (over 8600 adult subjects) except those already listed in the previous tables or elsewhere in labeling. In the tabulations that follow, a COSTART-based dictionary of terminology has been used to classify the reported adverse events. The frequencies presented, therefore, represent the proportion of the over 8600 adult individuals exposed to multiple doses of LYRICA who experienced an event of the type cited on at least 1 occasion while receiving LYRICA. It is important to emphasize that although the events reported occurred during treatment with LYRICA, they were not necessarily caused by it.

Less Common Clinical Trial Adverse Drug Reactions (<2%)

Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on 1 or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients.

Body System	Adverse Events
Body as a whole	
Frequent	Flu syndrome, back pain, allergic reaction, fever, generalized edema
Infrequent	Neck pain, neoplasm, cellulitis, cyst, chills, malaise, overdose, moniliasis, hernia, viral infection, photosensitivity reaction, pelvic pain, abdomen enlarged, abscess, neck rigidity, lab test abnormal, drug level increased, carcinoma, sepsis, suicide attempt, reaction unevaluable
Rare	Infection fungal, unexpected benefit, chills and fever, body odor, drug level decreased, halitosis, hangover effect, injection site reaction, hormone level altered, hyperthermia, infection bacterial, injection site hemorrhage, intentional overdose, mucous membrane disorder, accidental overdose, adenoma, anaphylactoid reaction, ascites, chest pain substernal, death, sarcoidosis, sudden death, immune system disorder, increased drug effect, injection site pain, lupus erythematosus syndrome, medication error, sarcoma, shock, tolerance decreased
Cardiovascular	
Frequent	Hypertension, vasodilatation
Infrequent	Palpitation, migraine, tachycardia, peripheral vascular disorder, electrocardiogram abnormal, cardiovascular disorder, angina pectoris, congestive heart failure, hemorrhage, myocardial infarct, hypertension, postural hypotension, ventricular extrasystoles, atrial fibrillation, coronary artery disorder, bradycardia, cerebrovascular accident, arrhythmia, cerebral ischemia, vascular disorder, sinus bradycardia, myocardial ischemia, bundle branch block, AV block first degree, arteriosclerosis, deep thrombophlebitis, phlebitis, arterial anomaly, heart failure, pulmonary embolus, retinal vascular disorder, varicose vein
Rare	Heart arrest, vascular anomaly, occlusion, supraventricular tachycardia, atrial arrhythmia, atrial flutter, cerebral infarct, coronary occlusion, thrombophlebitis, thrombosis, cardiomegaly, extrasystoles, pallor, AV block, AV block second degree, cardiomyopathy, peripheral gangrene, QT interval prolonged, retinal artery occlusion, supraventricular extrasystoles, cerebral hemorrhage, digitalis intoxication, ventricular arrhythmia, aortic stenosis, bigeminy, cerebrovascular disorder, left heart failure, ventricular tachycardia, AV block complete, carotid occlusion, carotid thrombosis, cor pulmonale, embolus lower extremity, endocarditis, heart block, increased capillary fragility, intracranial aneurysm, nodal tachycardia, QT interval shortened, retinal vein thrombosis, ST elevated, T inverted, vascular headache, vasculitis
Digestive system	
Frequent	Nausea, diarrhea, anorexia, gastrointestinal disorder
Infrequent	Gastroenteritis, tooth disorder, periodontal abscess, colitis, gastritis, liver function tests abnormal, increased salivation, thirst, nausea and vomiting, rectal disorder, gingivitis, dysphagia, stomatitis, mouth ulceration, cholelithiasis, rectal hemorrhage, gastrointestinal hemorrhage, glossitis, tooth caries, abnormal stools, cholecystitis, melena, oral moniliasis, esophagitis, tongue disorder, cheilitis, tongue edema
Rare	Eruaction, pancreatitis, stomach ulcer, ulcerative stomatitis, esophageal stenosis, fecal incontinence, gum hemorrhage, intestinal obstruction, enteritis, peptic ulcer, enterocolitis, gum hyperplasia, hepatomegaly, liver fatty deposit, tenesmus, biliary pain, focal impaction, jaundice, periodontitis, ulcerative colitis, aphthous stomatitis, cholestatic jaundice, gastrointestinal carcinoma, hemorrhagic gastritis, hepatitis, liver tenderness, nausea, vomiting and diarrhea, salivary gland enlargement, stomach atony, bloody diarrhea, cardiospasm, duodenal ulcer, gamma glutamyl transpeptidase increased, hematemesis, hepatoma, intestinal perforation, intestinal stenosis, intestinal ulcer, leukoplakia of mouth, necrotizing pancreatitis, pancreas disorder, pseudomembranous colitis, sialadenitis, stomach ulcer hemorrhage, tongue discoloration
Endocrine system	
Infrequent	Diabetes mellitus, hypothyroidism
Rare	Goiter, prolactin increased, thyroid disorder, gonadotropic follicle stim hormone increase, hyperthyroidism, thyroiditis, adrenal insufficiency, parathyroid disorder, thyroid carcinoma, thyroid neoplasia, virilism
Hemic and lymphatic	
Infrequent	Anemia, leukopenia, thrombocytopenia, lymphadenopathy, hypochromic anemia, leukocytosis, eosinophilia
Rare	Lymphocytosis, petechia, iron deficiency anemia, cyanosis, lymphedema, polycythemia, lymphoma like reaction, megaloblastic anemia, splenomegaly, purpura, thrombocytopenia, thrombocytopenic purpura, chronic leukemia, coagulation disorder, erythrocytes abnormal, leukemoid reaction, lymphangitis, macrocytic anemia, pancytopenia, prothrombin decreased, rupture of spleen, sedimentation rate increased

Body System	Adverse Events
Metabolic and nutritional	
Infrequent	Hyperglycemia, SGPT increased, hypoglycemia, hypokalemia, hypercholesterolemia, SGOT increased, weight loss, hyperlipidemia, amylase increased, hyperuricemia, alkaline phosphatase increased, creatinine increased, hyponatremia, gout, dehydration, BUN increased, healing abnormal
Rare	Hypercalcemia, hyperkalemia, hypocalcemia, bilirubinemia, alcohol intolerance, hypoglycemic reaction, ketosis, calcium disorder, hypochloremia, hypomagnesemia, hypoproteinemia, NPN increased, uremia, acidosis, avitaminosis, enzymatic abnormality, gamma globulins increased, hypernatremia, hypophosphatemia, lactic acidosis, obesity
Musculoskeletal system	
Frequent	Arthralgia, myalgia, arthritis, leg cramps, myasthenia
Infrequent	Tendon disorder, arthrosis, joint disorder, bone disorder, tenosynovitis, bursitis, tendinous contracture, osteoporosis, tendon rupture, bone pain
Rare	Rheumatoid arthritis, osteomyelitis, rhabdomyolysis, myopathy, muscle atrophy, myositis, pyogenic arthritis, bone neoplasm, musculoskeletal congenital anomaly, pathological fracture
Nervous system	
Frequent	Insomnia, anxiety, libido decreased, depersonalization, hypertonia, neuropathy
Infrequent	Reflexes decreased, sleep disorder, abnormal dreams, hostility, hallucinations, hyperkinesia, personality disorder, dysarthria, hyperesthesia, hypokinesia, circumoral paresthesia, libido increased, neuralgia, vestibular disorder, aphasia, movement disorder, hyperalgesia, apathy, hypotonia, convulsion, facial paralysis, psychosis
Rare	Drug dependence, neuritis, paranoid reaction, CNS depression, CNS neoplasia, manic reaction, neurosis, extrapyramidal syndrome, meningitis, hemiplegia, reflexes increased, akathisia, delirium, paralysis, withdrawal syndrome, brain edema, CNS stimulation, dyskinesia, encephalopathy, foot drop, grand mal convulsion, hypalgesia, peripheral neuritis, psychotic depression, addiction, arachnoiditis, cerebellar syndrome, cogwheel rigidity, dementia, dystonia, Guillain-Barre syndrome, intracranial hemorrhage, multiple sclerosis, myelitis, schizophrenic reaction, subarachnoid hemorrhage, torticollis
Respiratory system	
Frequent	Sinusitis, rhinitis, dyspnea, cough increased, pneumonia, lung disorder
Infrequent	Asthma, epistaxis, laryngitis, voice alteration, respiratory disorder, sputum increased
Rare	Apnea, emphysema, aspiration pneumonia, hyperventilation, lung edema, pleural disorder, atelectasis, hemoptysis, hiccup, hypoxia, laryngismus, lung fibrosis, pleural effusion, lung function decreased, pulmonary hypertension, yawn, bronchiectasis, bronchiolitis, carcinoma of lung, hypoventilation, laryngeal neoplasia, nasal septum disorder, pneumothorax
Skin and appendages	
Infrequent	Pruritus, sweating, skin disorder, acne, dry skin, alopecia, skin ulcer, herpes simplex, urticaria, nail disorder, eczema, herpes zoster, skin benign neoplasm, fungal dermatitis, maculopapular rash, vesiculobullous rash, skin carcinoma, furunculosis, skin discoloration, skin hypertrophy, psoriasis, seborrhea, hirsutism
Rare	Skin nodule, angioedema, cutaneous moniliasis, skin atrophy, exfoliative dermatitis, pustular rash, ichthyosis, skin melanoma, subcutaneous nodule, sweating decreased, hair disorder, lichenoid dermatitis, melanosis, miliaria, purpuric rash, skin necrosis, Stevens Johnson syndrome
Special sense	
Frequent	Eye disorder, conjunctivitis, otitis media
Infrequent	Retinal disorder, tinnitus, eye pain, cataract specified, dry eyes, taste perversion, ear pain, lacrimation disorder, ear disorder, deafness, eye hemorrhage, photophobia, glaucoma, vitreous disorder, corneal lesion, otitis externa, refraction disorder, blepharitis, retinal edema, taste loss, abnormality of accommodation
Rare	Hyperacusis, keratitis, mydriasis, parosmia, ptosis, retinal hemorrhage, color blindness, retinal pigmentation, retinal detachment, corneal opacity, corneal ulcer, iritis, night blindness, optic atrophy, retinal degeneration, cataract NDS, scleritis, strabismus, anisocoria, blindness, exophthalmos, keratoconjunctivitis, ophthalmoplegia, papilledema
Urogenital system	
Frequent	Anorgasmia
Infrequent	Urinary frequency, urinary incontinence, cystitis, abnormal ejaculation, urination impaired, dysuria, metrorrhagia, hematuria, vaginal moniliasis, prostatic disorder, vaginitis, dysmenorrhea, urinary urgency, kidney calculus, breast pain, menstrual disorder, amenorrhea, menorrhagia, kidney function abnormal, nephritis, urine abnormality, vaginal hemorrhage, urinary retention, urinary tract disorder, leukorrhea, breast neoplasm, menopause, oliguria, polyuria, albuminuria, pyuria
Rare	Breast carcinoma, penis disorder, papanoicolau smear suspicious, fibrocystic breast, prostatic carcinoma, uterine fibroids enlarged, acute kidney failure, creatinine clearance decreased, nephrosis, nocturia, polycystic kidney, bladder carcinoma, breast enlargement, cervicitis, cervix disorder, female lactation, glycosuria, gynecostasia, hypomenorrhea, kidney pain, mastitis, pyelonephritis, kidney failure, breast abscess, epididymitis, orchitis, prostate neoplasia, prostatic specific antigen increase, salpingitis, urogenital disorder, urolithiasis, uterine disorder, vulvovaginal disorder, balanitis, bladder calculus, calcium crystalluria, cervix neoplasm, dyspareunia, endometrial carcinoma, endometrial disorder, glomerulitis, hydronephrosis, ovarian cancer, unintended pregnancy, urethral pain, urethritis, urogenital anomaly, urogenital neoplasia, uterine hemorrhage

Comparison of Gender and Race

The overall adverse event profile of pregabalin was similar between women and men. There are insufficient data to support a statement regarding the distribution of adverse experience reports by race.

Peripheral Edema

Incidence of peripheral edema in controlled neuropathic pain studies was 10.4% in the pregabalin group compared with 2.9% in the placebo group. In clinical trials, these events of peripheral edema were dose-related, mostly mild to moderate in intensity and rarely led to withdrawal. Peripheral edema was not associated with cardiovascular complications such as hypertension or congestive heart failure and there was no evidence of hemodilution or changes in any laboratory parameters indicative of underlying organ dysfunction (see **WARNINGS AND PRECAUTIONS, Peripheral Edema**).

Weight Gain

In the controlled neuropathic pain studies, patients on pregabalin had a higher incidence (5.9%) of weight gain as defined by a $\geq 7\%$ increase from baseline weight as compared with the placebo group (1.6%). The mean change in the pregabalin group was an increase of 1.5 kg compared with 0.2 kg in the placebo group, few patients (0.1%) withdrew due to weight gain. This weight gain was dose-related, and not associated with clinically important changes in blood pressure or cardiovascular adverse events. There was no relationship between baseline body mass index and the incidence of $\geq 7\%$ weight gain in the controlled trials.

Based on the results of a controlled study of reproductive function in healthy male volunteers, the $\geq 7\%$ weight gain on pregabalin appeared to be reversible. In this study, there were no reports of peripheral edema (see **WARNINGS AND PRECAUTIONS, Weight Gain**).

Abnormal Hematologic and Clinical Chemistry Findings

In all controlled trials, 1.0% of patients on pregabalin and 0.5% of placebo patients had an increase in creatine kinase of $>3x$ upper limit of normal. Renal dysfunction was generally not associated with the elevated creatine kinase in these patients. Mean changes in creatine kinase ranged from 9.6 to 26.3 U/L for pregabalin-treated patients and 4.8 U/L for the placebo patients (see **DOSE AND ADMINISTRATION, Patients with Renal Impairment**). Routine therapeutic drug monitoring or clinical laboratory testing is not required for patients treated with LYRICA (see **WARNINGS AND PRECAUTIONS**).

Post-Marketing Adverse Drug Reactions

The worldwide post-marketing experience to date with LYRICA is consistent with the clinical program. The most frequently reported adverse events from spontaneous post-marketing reports for LYRICA are shown below. There are insufficient data to support an estimate of their incidence or to establish causation.

Eye disorders: diplopia, vision blurred, visual disturbance. There have also been rare reports of accommodation disorder, eyelid edema and eye redness (see **WARNINGS AND PRECAUTIONS, Ophthalmological Effects**).

Gastrointestinal disorders: diarrhea, dry mouth, nausea, vomiting

General disorders and administration site conditions: fatigue, feeling abnormal, pain

Nervous system disorders: ataxia, coordination abnormal, dizziness, dysarthria, headache, memory impairment, paresthesia, somnolence, speech disorder, tremor (see **WARNINGS AND PRECAUTIONS, Dizziness and Somnolence**)

Psychiatric disorders: confusional state, depression, insomnia, psychotic disorder. There have been rare reports of psychotic disorders in patients receiving pregabalin.

Renal and urinary disorders: urinary retention

Respiratory, thoracic and mediastinal disorders: dyspnea

Skin and subcutaneous tissue disorders: pruritus

DRUG INTERACTIONS

Overview

Since pregabalin is predominately excreted unchanged in the urine, undergoes negligible metabolism in humans (<2% of a dose recovered in urine as metabolites), does not inhibit drug metabolism in vitro, and is not bound to plasma proteins, LYRICA (pregabalin) is unlikely to produce, or be subject to, pharmacokinetic interactions.

Pharmacokinetic

In Vitro Studies: In vitro drug metabolism studies revealed that pregabalin at concentrations which were, in general, 10-fold greater than observed in Phase 2/3 clinical trials, does not inhibit human CYP1A2, CYP2A6, CYP2C9, CYP2C19, CYP2D6, CYP2E1, and CYP3A4 enzyme systems.

In Vivo Studies: The drug interaction data described in this section were obtained from studies involving healthy adults, patients with epilepsy, and patients with chronic pain disorders.

Carbamazepine, valproic acid, lamotrigine, phenytoin, phenobarbital, and topiramate

In vitro and in vivo studies showed that LYRICA is unlikely to be involved in significant pharmacokinetic drug interactions. Specifically, there are no clinically significant pharmacokinetic interactions between pregabalin and the following antiepileptic drugs: carbamazepine, valproic acid, lamotrigine, phenytoin, phenobarbital, and topiramate. Important pharmacokinetic interactions would also not be expected to occur between pregabalin and commonly used antiepileptic drugs.

Tiagabine: The results of a population pharmacokinetic analysis indicated that in patients with partial seizures tiagabine had no clinically significant effect on pregabalin clearance.

Gabapentin: The pharmacokinetics of pregabalin and gabapentin were investigated in 12 healthy subjects following concomitant single dose administration of 100 mg pregabalin and 300 mg gabapentin, and in 18 healthy subjects following concomitant multiple dose administration of 200 mg pregabalin q8h and 400 mg gabapentin q8h. Gabapentin pharmacokinetics following single and multiple dose administration were unaltered by pregabalin coadministration. The rate of pregabalin absorption was reduced by approximately 26% (single dose administration) and 18% (multiple dose administration) based on lower C_{max} values; however, the extent of pregabalin absorption was unaffected by gabapentin coadministration.

Oral Contraceptives: Pregabalin coadministration (200 mg TID) had no effect on the steady state pharmacokinetics of norethindrone and ethinyl estradiol (1 mg/35 µg, respectively) in healthy subjects.

Lorazepam: Multiple dose administration of pregabalin (300 mg BID) in healthy subjects had no effect on the rate and extent of lorazepam single dose pharmacokinetics and single dose administration of lorazepam (1 mg) had no clinically significant effect on the steady state pharmacokinetics of pregabalin.

Oxycodone: Multiple dose administration of pregabalin (300 mg BID) in healthy subjects had no effect on the rate and extent of oxycodone single dose pharmacokinetics. Single dose administration of oxycodone (10 mg) had no clinically significant effect on the steady state pharmacokinetics of pregabalin.

Ethanol: Multiple dose administration of pregabalin (300 mg BID) in healthy subjects had no effect on the rate and extent of ethanol single dose pharmacokinetics and single dose administration of ethanol (0.7 g/kg) had no clinically significant effect on the steady state pharmacokinetics of pregabalin.

Diuretics, Oral Hypoglycemics, and Insulin: A population pharmacokinetic analysis in patients with chronic pain showed no clinically significant effect on pregabalin clearance with the concomitant use of diuretics, oral hypoglycemics, and insulin.

Pharmacodynamic

Multiple oral doses of pregabalin co-administered with oxycodone, lorazepam, or ethanol did not result in clinically important effects on respiration. Pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone. Pregabalin may potentiate the effects of ethanol and lorazepam.

Drug-Food Interactions

The rate of pregabalin absorption is decreased when given with food resulting in a decrease in C_{max} by approximately 25% to 30% and an increase in T_{max} to approximately 3 hours. However, administration of pregabalin with food has no clinically relevant effect on the total amount of pregabalin absorbed. Therefore, pregabalin can be taken with or without food.

Drug-Herb Interactions

LYRICA (pregabalin) has no known drug/herb interactions.

Drug-Laboratory Interactions

LYRICA (pregabalin) has no known drug/laboratory test interactions.

DOSE AND ADMINISTRATION

Dosing Considerations

Patients with Impaired Renal Function

Pregabalin is primarily eliminated from the systemic circulation by renal excretion as unchanged drug. In patients with a medical history of significant renal insufficiency, daily doses should be reduced accordingly (see **Dosage Adjustment Based on Renal Function**, below).

In accordance with current clinical practice, if LYRICA (pregabalin) has to be discontinued, it is recommended this should be done gradually over a minimum of 1 week (see **WARNINGS AND PRECAUTIONS, Abrupt or Rapid Discontinuation**).

Adults:

Neuropathic pain associated with diabetic peripheral neuropathy

The recommended starting dose for LYRICA is 150 mg/day, given in two or three divided doses (75 mg BID or 50 mg TID), with or without food in patients with a creatinine clearance rate of at least 60 mL/min. Efficacy of LYRICA has been demonstrated within the first week. Based on individual patient response and tolerability, the dose may be increased to 150 mg BID (300 mg/day) after one week.

For patients who experience significant and ongoing pain and can tolerate pregabalin 300 mg/day well, maximum daily dose of 600 mg (300 mg twice a day, BID) can be used. However, in clinical trials, LYRICA 600 mg/day did not provide additional significant efficacy and patients treated with this dose experienced markedly higher rates of adverse events and discontinued the trial more frequently.

Neuropathic pain associated with postherpetic neuralgia

The recommended starting dose for LYRICA is 150 mg/day, given in two or three divided doses (75 mg BID or 50 mg TID), with or without food in patients with a creatinine clearance rate of at least 60 mL/min. Efficacy of LYRICA has been demonstrated within the first week. Based on individual patient response and tolerability, the dose may be increased to 150 mg BID (300 mg/day) after one week.

For patients who experience significant and ongoing pain and can tolerate pregabalin 300 mg/day well, maximum daily dose of 600 mg (300 mg twice a day, BID) can be used. However, in clinical trials, LYRICA 600 mg/day did not provide additional significant efficacy and patients treated with this dose experienced markedly higher rates of adverse events and discontinued the trial more frequently.

Dosage Adjustment Based on Renal Function

LYRICA is primarily eliminated by renal excretion. Therefore, the dose should be adjusted for patients with reduced renal function. Pregabalin clearance is directly proportional to creatinine clearance. Therefore, dosing adjustment should be based on creatinine clearance (CL_{cr}), as indicated in Table 7.

To use this dosing table, an estimate of the patient's creatinine clearance (CL_{cr}) in mL/min is needed. CL_{cr} in mL/min may be estimated from serum creatinine (mg/dL) determination using the Cockcroft and Gault equation:

$$CL_{cr} = \frac{[140 - \text{age (years)}] \times \text{weight (kg)}}{72 \times \text{serum creatinine (mg/dL)}} \quad (\times 0.85 \text{ for female patients})$$

Pregabalin is effectively removed from plasma by hemodialysis. Over a 4-hour hemodialysis treatment, plasma pregabalin concentrations are reduced by approximately 50%. For patients receiving hemodialysis, pregabalin daily dose should be adjusted based on renal function, in addition to the daily dose adjustment, a supplemental dose should be given immediately following every 4-hour hemodialysis treatment (see Table 7).

Treatment or Management of Overdose

There is no specific antidote for overdose with pregabalin. If indicated, elimination of unabsorbed drug may be attempted by emesis or gastric lavage; usual precautions should be observed to maintain the airway. General supportive care of the patient is indicated including monitoring of vital signs and observation of the clinical status of the patient. A Certified Poison Control Center should be contacted for up-to-date information on the management of overdose with pregabalin.

Hemodialysis

Standard hemodialysis procedures result in significant clearance of pregabalin (approximately 50% in 4 hours) and should be considered in cases of overdose. Although hemodialysis has not been performed in the few known cases of overdose, it may be indicated by the patient's clinical state or in patients with significant renal impairment.

ACTION AND CLINICAL PHARMACOLOGY

Mechanism of Action

Pharmacodynamics

LYRICA (pregabalin) binds with high affinity to the $\alpha_2\delta$ protein (a calcium channel subunit) of brain tissues and has analgesic, antiepileptic and anxiolytic activity. Pregabalin is known chemically as (S)-3-(aminomethyl)-5-methylhexanoic acid.

Although the mechanism of action of pregabalin is unknown, results with genetically modified mice and with compounds structurally-related to pregabalin indicate that selective binding to the $\alpha_2\delta$ protein is required for analgesic, antiepileptic and anxiolytic action in animal models. In vivo, pregabalin reduces the release of several neurotransmitters, suggesting a modulatory action on calcium channel function.

Pregabalin does not mimic GABA at GABA_A or GABA_B receptors, nor does it augment GABA_A responses like benzodiazepines or barbiturates. In contrast to vascular calcium channel blockers, pregabalin does not alter systemic blood pressure or cardiac function. Various *in vitro* and *in vivo* results differentiate pregabalin from GABA uptake inhibitors or GABA transaminase inhibitors. In addition, pregabalin does not block sodium channels, it is not active at opiate receptors, it does not alter cyclooxygenase enzyme activity, it is not a serotonin agonist, it is not a dopamine antagonist, and it is not an inhibitor of dopamine, serotonin or noradrenaline reuptake.

Pregabalin treatment reduces pain-related behavior in neuropathic animal models of diabetes, peripheral nerve damage or chemotherapeutic insult and in a model of musculoskeletal-associated pain. Pregabalin given intrathecally prevents pain-related behaviors and reduces pain-related behavior caused by spinally administered agents, suggesting that it acts directly on tissues of the spinal cord or brain.

Pharmacokinetics

All pharmacological actions following pregabalin administration are due to the activity of the parent compound; pregabalin is not appreciably metabolized in humans. Mean steady-state plasma pregabalin concentration-time profiles following 75, 300 and 600 mg daily given in equally divided doses every 8 hours (TID) and 600 mg/day given in equally divided doses every 12 hours (BID) are shown in Table 8. Pregabalin pharmacokinetics are linear over the recommended daily dose range. Inter-subject pharmacokinetic variability for pregabalin is low (<20%).

Table 8. Pregabalin Mean (CV%)* Steady-State Pharmacokinetic Parameter Values in Healthy Volunteers

Dose (mg)	Regimen	Daily Dose (mg/day)	n	C_{max} ($\mu\text{g/mL}$)	t_{max} (hr)	C_{min} ($\mu\text{g/mL}$)	AUC ₀₋₉ ($\mu\text{g}\cdot\text{hr/mL}$)	$t_{1/2}$ (hr)	$C_{L/F}$ (mL/min)
25	TID ^b	75	8	1.39	0.9	0.45	6.7	5.9	64.1
			6	-19.5	-34.2	-25	-18.3	-17.3	-16.1
100	TID	300	6	5.03	0.8	1.94	25.2	6.3	68.9
			6	-21.3	-31	-33.6	-23	-19.6	-20.9
200	TID	600	11	8.52	0.9	3.28	41.7	6.3	81
			6	-14.8	-22.2	-29.2	-12.8	-13.6	-11.7
300	BID ^c	600	8	9.07	1.4	2.6	59	6.7	85.1
			6	-10.5	-57.1	-15.5	-6.4	-16.2	-6.4

C_{max} : Steady-state peak plasma concentration.
 C_{min} : Steady-state trough plasma concentration.
 t_{max} : Time of peak plasma concentration at steady state.
 $C_{L/F}$: Steady state trough plasma concentration.
AUC₀₋₉: Area under the plasma concentration-time curve during one dosing interval at steady state.
 $t_{1/2}$: Elimination half-life.
 $C_{L/F}$: Oral clearance.

Table 7. Pregabalin Dosage Adjustment Based on Renal Function

Creatinine Clearance (CL_{cr}) (mL/min)	Total Pregabalin Daily Dose (mg/day) ^a	Dose Regimen
≥ 60	150, 300, 600	BID or TID
30-60	75, 150, 300	BID or TID
15-30	25-50, 75, 150	QD or BID
<15	25, 25-50, 75	QD
Supplementary dosage following hemodialysis (mg) ^b		
Patients on the 25 mg QD regimen: take one supplemental dose of 25 mg or 50 mg		
Patients on the 25-50 mg QD regimen: take one supplemental dose of 50 mg or 75 mg		
Patients on the 75 mg QD regimen: take one supplemental dose of 100 mg or 150 mg		

TID = Three divided doses; BID = Two divided doses; QD = Single daily dose.
a Total daily dose (mg/day) should be divided as indicated by dose regimen to provide mg/dose.
b Supplementary dose is a single additional dose.

Geriatrics (>65 years): Pregabalin oral clearance tended to decrease with increasing age. This decrease in pregabalin oral clearance is consistent with age-related decreases in creatinine clearance. Reduction of pregabalin dose may be required in patients who have age-related compromised renal function.

Pediatrics (<18 years of age): The safety and efficacy of pregabalin in pediatric patients (<18 years of age) have not been established and its use in this patient population is not recommended.

Administration

LYRICA (pregabalin) is given orally with or without food (see **ACTION AND CLINICAL PHARMACOLOGY**).

OVERDOSAGE

Signs, Symptoms and Laboratory Findings of Acute Overdosage in Humans
The highest known dose of pregabalin received in the clinical development program was 15,000 mg in 1 patient. The types of adverse events experienced by patients who received an overdose were not clinically different from other patients receiving recommended doses of pregabalin.

Distribution: In preclinical studies, pregabalin has been shown to readily cross the blood brain barrier in mice, rats and monkeys. Pregabalin is a substrate for system L transporter which is responsible for the transport of large amino acids across the blood-brain barrier. Pregabalin has been shown to cross the placenta in rats and is present in the milk of lactating rats. In humans, the apparent volume of distribution of pregabalin following oral administration is approximately 0.5 L/kg. Pregabalin is not bound to plasma proteins. At clinically efficacious doses of 150 and 600 mg/day, the average steady state plasma pregabalin concentrations were approximately 1.5 and 6.0 $\mu\text{g/mL}$, respectively.

Metabolism: Pregabalin undergoes negligible metabolism in humans. Following a dose of radiolabeled pregabalin, approximately 98% of the radioactivity recovered in the urine was unchanged pregabalin. The N-methylated derivative of pregabalin, the major metabolite of pregabalin found in urine, accounted for 0.9% of the dose. In preclinical studies, pregabalin (S-enantiomer) did not undergo racemization to the R-enantiomer in mice, rats, rabbits or monkeys.

Excretion: Pregabalin is eliminated from the systemic circulation primarily by renal excretion as unchanged drug. Pregabalin mean $t_{1/2}$ is 6.3 hours. Pregabalin elimination is proportional to creatinine clearance. Pregabalin clearance is reduced in patients with impaired renal function (see **DOSE AND ADMINISTRATION**).

Special Populations and Conditions

Pregabalin undergoes negligible metabolism, is not bound to plasma proteins and is eliminated predominantly as unchanged drug by renal excretion. Clinically important differences in pregabalin pharmacokinetics due to race and gender have not been observed and are not anticipated.

Pediatrics: Pharmacokinetics of pregabalin have not been studied in paediatric patients.

Geriatrics: Pregabalin oral clearance tended to decrease with increasing age. This decrease in pregabalin oral clearance is consistent with age-related decreases in creatinine clearance. Reduction of pregabalin dose may be required in patients who have age-related compromised renal function (see **WARNINGS AND PRECAUTIONS AND DOSE AND ADMINISTRATION**).

Gender: A population pharmacokinetic analysis of the Phase 2/3 clinical program showed that the relationship between daily dose and pregabalin drug exposure is similar between genders when adjusted for gender-related differences in creatinine clearance.

Race: A population pharmacokinetic analysis of the Phase 2/3 clinical program showed that the relationship between daily dose and pregabalin drug exposure is similar among Caucasians, Blacks and Hispanics.

Renal Insufficiency: Because renal elimination is the major elimination pathway, dosage reduction in patients with renal dysfunction is necessary. Pregabalin is effectively removed from plasma by hemodialysis. Following a 4-hour hemodialysis treatment, plasma pregabalin concentrations are reduced by approximately 50%. For patients on hemodialysis, dosing must be modified (see **DOSE AND ADMINISTRATION**).

STORAGE AND STABILITY

Store at 15°C-30°C.

DOSE FORMS, COMPOSITION AND PACKAGING

Each capsule of LYRICA (pregabalin) contains 25, 50, 75, 150 or 300 mg pregabalin, lactose monohydrate, maize starch and talc. The capsule shells contain gelatin and titanium dioxide. In addition, the orange capsule shells contain red iron oxide and the white capsule shells contain sodium lauryl sulfate and colloidal silicon dioxide. Colloidal silicon dioxide is a manufacturing aid, which may not be present. The markings on the capsules are in black ink, which contains shellac, black iron oxide, propylene glycol, potassium hydroxide and water.

Capsules are packaged in HDPE bottles containing 60 capsules, and PVC/aluminum blisters.

PHARMACEUTICAL INFORMATION

Drug Substance

Proper name: pregabalin
Chemical name: (S)-3-(aminomethyl)-5-methylhexanoic acid

Molecular formula: $C_8H_{17}NO_2$
 C_{max} : Steady-state peak plasma concentration.
 t_{max} : Time of peak plasma concentration at steady state

C_{min} : Steady state trough plasma concentration
AUC₀₋₉: Area under the plasma concentration-time curve during one dosing interval at steady state

$t_{1/2}$: Elimination half-life
 $C_{L/F}$: Oral clearance

a: Percent coefficient of variation
b: Total daily dose given in equally divided doses every 8 hours
c: Total daily dose given in equally divided doses every 12 hours

Absorption: Pregabalin is rapidly absorbed when administered in the fasted state, with peak plasma concentrations occurring within 1.5 hours following both single- and multiple-dose administration. Pregabalin oral bioavailability is $\geq 90\%$ and is independent of dose. C_{max} (Figure 1) and AUC values increase proportionally following single- and multiple-dose administration. Following repeated administration, steady state is achieved within 24 to 48 hours. Multiple dose pharmacokinetics are predictable from single-dose data.

Figure 1. Individual and Mean Steady-State Pregabalin C_{max} Values Following 75, 300 and 600 mg/day Given in Equally Divided Doses TID (q8h) to Healthy Volunteers*

Product Monograph available at www.pfizer.com
Last revised: June 3, 2005

References:
1. LYRICA Product Monograph, study 1008-196, neuropathic pain evaluation, multicentre, placebo-controlled trial of flexible- and fixed-dose regimens. Pain 2005;115:254-263.

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1. LYRICA Product Monograph, study 1008-196, neuropathic pain evaluation, multicentre, placebo-controlled trial of flexible- and fixed-dose regimens. Pain 2005;115:254-263.

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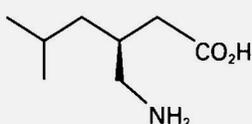
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C₈H₁₇NO₂

159.23



Pregabalin is a white crystalline solid. It is soluble in water and in both basic and acidic aqueous solutions.

upon request.

ph, June 2005. 2. Data on file, Pfizer Canada Freynhagen R, et al. Efficacy of pregabalin in a 12-week, randomised, double-blind, trial of flexible- and fixed-dose regimens.

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Kirkland, Quebec
H91 2M5

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PHARMACOLOGIC CLASSIFICATION:
Angiotensin Converting Enzyme Inhibitor

ACTION AND CLINICAL PHARMACOLOGY

ALTA^{CE} (ramipril) is an angiotensin converting enzyme (ACE) inhibitor. Following oral administration, ALTA^{CE} is rapidly hydrolyzed to ramiprilat, its principal active metabolite.

INDICATIONS AND CLINICAL USE: *Essential Hypertension.* ALTA^{CE} (ramipril) is indicated in the treatment of essential hypertension. It may be used alone or in association with thiazide diuretics. ALTA^{CE} should normally be used in patients in whom treatment with a diuretic or a beta-blocker was found ineffective or has been associated with unacceptable adverse effects. ALTA^{CE} can also be used as an initial agent in those patients in whom use of diuretics and/or beta-blockers are contraindicated or in patients with medical conditions in which these drugs frequently cause serious adverse effects. The safety and efficacy of ALTA^{CE} in renovascular hypertension have not been established and therefore, its use in this condition is not recommended. The safety and efficacy of concurrent use of ALTA^{CE} with antihypertensive agents other than thiazide diuretics have not been established.

Treatment Following Acute Myocardial Infarction
ALTA^{CE} is indicated following acute myocardial infarction in clinically stable patients with signs of left ventricular dysfunction to improve survival and reduce hospitalizations for heart failure. Sufficient experience in the treatment of patients with severe (NHA class IV) heart failure immediately after myocardial infarction is not yet available. (See WARNINGS – Hypertension.)

MANAGEMENT OF PATIENTS AT INCREASED RISK OF CARDIOVASCULAR EVENTS: ALTA^{CE} may be used to reduce the risk of myocardial infarction, stroke or cardiovascular death in patients over 55 years of age who are at high risk of cardiovascular events because of a history of coronary artery disease, stroke, peripheral artery disease, or diabetes that is accompanied by at least one other cardiovascular risk factor such as hypertension, elevated total cholesterol levels, low high density lipoprotein levels, cigarette smoking, or documented microalbuminuria. The incidence of the primary outcome (composite of myocardial infarction, stroke and death from cardiovascular causes) was reduced from 17.8% in the placebo-treated group to 14.0% in the ramipril-treated group.

GENERAL: In using ALTA^{CE} consideration should be given to the risk of angioedema (see WARNINGS). When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury or even death of the developing fetus. When pregnancy is detected ALTA^{CE} should be discontinued as soon as possible (see WARNINGS – Use in Pregnancy, and INFORMATION FOR THE PATIENT).

CONTRAINDICATIONS: ALTA^{CE} (ramipril) is contraindicated in patients who are hypersensitive to this drug, or to any ingredient in the formulation, or in those patients who have a history of angioedema.

WARNINGS: Angioedema. Angioedema has been reported in patients with ACE inhibitors, including ALTA^{CE} (ramipril). Angioedema associated with laryngeal involvement may be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, ALTA^{CE} should be discontinued immediately, the patient treated appropriately in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment, although antihistamines may be useful in relieving symptoms. Where there is involvement of tongue, glottis, or larynx, likely to cause airway obstruction, appropriate therapy (including, but not limited to 0.3 to 0.5 mL of subcutaneous epinephrine solution 1:1000) should be administered promptly (see ADVERSE REACTIONS).

The incidence of angioedema during ACE inhibitor therapy has been reported to be higher in black than in non-black patients. Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see CONTRAINDICATIONS).

Hypertension: Symptomatic hypotension has occurred after administration of ALTA^{CE}, usually after the first or second dose or when the dose was increased. It is more likely to occur in patients who are volume depleted by diuretic therapy, dietary salt restriction, dialysis, diarrhea, or vomiting. In patients with ischemic heart disease or cerebrovascular disease, an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident (see ADVERSE REACTIONS). Because of the potential fall in blood pressure in these patients, therapy with ALTA^{CE} should be started under close medical supervision. Such patients should be followed closely for the first weeks of treatment and whenever the dose of ALTA^{CE} is increased. In patients with severe congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension and has been associated with oliguria, and/or progressive azotemia, and rarely, with acute renal failure and/or death.

If hypotension occurs, the patient should be placed in a supine position and, if necessary, receive an intravenous infusion of 0.9% sodium chloride. A transient hypotensive response may not be a contraindication to further doses which usually can be given without difficulty once the blood pressure has increased after volume expansion in hypertensive patients. However, lower doses of ALTA^{CE} and/or reduced concomitant diuretic therapy should be considered. In patients receiving treatment following acute myocardial infarction, consideration should be given to discontinuation of ALTA^{CE} (see ADVERSE REACTIONS – Treatment Following Acute Myocardial Infarction, DOSAGE AND ADMINISTRATION – Treatment Following Acute Myocardial Infarction).

Neutropenia/Agranulocytosis: Agranulocytosis and bone marrow depression have been caused by ACE inhibitors. Several cases of agranulocytosis, neutropenia or leukopenia have been reported in which a causal relationship to ALTA^{CE} cannot be excluded. Current experience with the drug shows the incidence to be rare. Periodic monitoring of white blood cell counts should be considered, especially in patients with collagen vascular disease and/or renal disease. Use in Pregnancy: ACE inhibitors can cause fetal and neonatal morbidity and mortality when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ALTA^{CE} should be discontinued as soon as possible.

PRECAUTIONS: Renal Impairment: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function have been seen in susceptible individuals. In patients whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, such as patients with bilateral renal artery stenosis, unilateral renal artery stenosis to a solitary kidney, or severe congestive heart failure, treatment with agents that inhibit this system has been associated with oliguria, progressive azotemia, and rarely, acute renal failure and/or death. In susceptible patients, concomitant diuretic use may further increase risk. Use of ALTA^{CE} should include appropriate assessment of renal function. ALTA^{CE} should be used with caution in patients with renal insufficiency as they may require reduced or less frequent doses (see DOSAGE AND ADMINISTRATION). Close monitoring of renal function during therapy should be performed as deemed appropriate in patients with renal insufficiency.

Anaphylactoid Reactions during Membrane Exposure: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g. polyacrylonitrile [PAN]) and treated concomitantly with an ACE inhibitor. Dialysis should be stopped immediately if symptoms such as nausea, abdominal cramps, burning, angioedema, shortness of breath and severe hypotension occur. Symptoms are not relieved by antihistamines. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agents.

Anaphylactoid Reactions during Desensitization: There have been isolated reports of

patients experiencing sustained life threatening anaphylactoid reactions while receiving ACE inhibitors during desensitization treatment with hymenoptera (bees, wasps) venom. In the same patients, these reactions have been avoided when ACE inhibitors were temporarily withheld for at least 24 hours, but they have reappeared upon inadvertent rechallenge.

Hyperkalemia and Potassium-Sparing Diuretics: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials treated with ALTA^{CE}. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was not a cause of discontinuation of therapy in any hypertensive patient. Risk factors for the development of hyperkalemia may include renal insufficiency, diabetes mellitus, and the concomitant use of agents to treat hypokalemia or other drugs associated with increases in serum potassium (see PRECAUTIONS – Drug Interactions).

Surgery/Anesthesia: In patients undergoing surgery or anesthesia with agents producing hypotension, ALTA^{CE} may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it may be corrected by volume repletion.

Aortic Stenosis: There is concern, on theoretical grounds, that patients with aortic stenosis might be at particular risk of decreased coronary perfusion when treated with vasodilators because they do not develop as much afterload reduction.

Patients with Impaired Liver Function: Hepatitis (hepatocellular and/or cholestatic), elevations of liver enzymes and/or serum bilirubin have occurred during therapy with ACE inhibitors in patients with or without pre-existing liver abnormalities. In most cases the changes were reversed on discontinuation of the drug.

Elevations of liver enzymes and/or serum bilirubin have been reported with ALTA^{CE} (see ADVERSE REACTIONS). Should the patient receiving ALTA^{CE} experience any unexplained symptoms particularly during the first weeks or months of treatment, it is recommended that a full set of liver function tests and any other necessary investigations be carried out. Discontinuation of ALTA^{CE} should be considered when appropriate. There are no adequate studies in patients with cirrhosis and/or liver dysfunction. ALTA^{CE} should be used with particular caution in patients with pre-existing liver abnormalities. In such patients baseline liver function tests should be obtained before administration of the drug and close monitoring of response and metabolic effects should apply.

Nursing Mothers: Ingestion of a single 10 mg oral dose of ALTA^{CE} resulted in undetectable amounts of ramipril and its metabolites in breast milk. However, because multiple doses may produce low milk concentrations that are not predictable from single doses, ALTA^{CE} should not be administered to nursing mothers.

Pediatric Use: The safety and effectiveness of ALTA^{CE} in children have not been established; therefore use in this age group is not recommended.

Use in Elderly: Although clinical experience has not identified differences in response between the elderly (>65 years) and younger patients, greater sensitivity of some older individuals cannot be ruled out.

Patient Alertness: ALTA^{CE} may lower the state of patient alertness and/or reactivity, particularly at the start of treatment (see ADVERSE REACTIONS).

Cough: A dry, persistent cough, which usually disappears only after withdrawal or lowering of the dose of ALTA^{CE}, has been reported. Such possibility should be considered as part of the differential diagnosis of cough.

Drug Interactions: Concomitant Diuretic Therapy: Hypotension may result but can be minimized by discontinuing diuretic or increasing salt intake prior to ramipril treatment and/or reducing initial dose. **Agents increasing serum potassium:** Use potassium sparing diuretics with caution and monitor frequently. **Agents causing renin release:** ALTA^{CE} antihypertensive effect increased. **Lithium:** Lithium levels may be increased. Administer lithium with caution and monitor levels frequently. **Antacids:** The bioavailability of ALTA^{CE} and the pharmacokinetics of ramipril were not affected. **Digoxin:** No change in ramipril, ramiprilat or digoxin serum levels. **Warfarin:** The co-administration of ALTA^{CE} with warfarin did not alter the anticoagulant effects. **Acenocoumarol:** No significant changes. **Non-steroidal anti-inflammatory agents (NSAID):** The antihypertensive effects of ACE inhibitors may be reduced with concomitant administration of NSAIDs (e.g. indomethacin).

ADVERSE REACTIONS: Essential Hypertension. Serious adverse events occurring in North American placebo-controlled clinical trials with ramipril monotherapy in hypertension (n=972) were: hypotension (0.1%); myocardial infarction (0.3%); cerebrovascular accident (0.1%); edema (0.2%); syncope (0.1%). Among all North American ramipril patients (n=1,244), angioedema occurred in patients treated with ramipril and a diuretic (0.1%). The most frequent adverse events occurring in these trials with ALTA^{CE} monotherapy in hypertensive patients (n=651) were: headache (15.1%); dizziness (3.7%); asthenia (3.7%); chest pain (2.0%); nausea (1.8%); peripheral edema (1.8%); somnolence (1.7%); impotence (1.5%); rash (1.4%); arthritis (1.1%); dyspnea (1.1%). Discontinuation of therapy due to clinical adverse events was required in 5 patients (0.8%). In placebo-controlled trials, an excess of upper respiratory infection and flu syndrome was seen in the ramipril group. As these studies were carried out before the relationship of cough to ACE inhibitors was recognized, some of these events may represent ramipril-induced cough. In a later 1-year study, increased cough was seen in almost 12% of ALTA^{CE} patients, with about 4% of these patients requiring discontinuation of treatment. Approximately 1% of patients treated with ALTA^{CE} monotherapy in North American controlled clinical trials (n=972) have required discontinuation because of cough.

Treatment Following Acute Myocardial Infarction
Adverse events (except laboratory abnormalities) in a controlled clinical trial of post-AMI patients with clinical signs of heart failure considered possibly/probably related to ALTA^{CE} and occurring in more than 1% of stabilized patients (n=1,004) were: hypotension (10.7%); increased cough (7.6%); dizziness/vertigo (5.6%); nausea/vomiting (3.8%); angina pectoris (2.9%); postural hypotension (2.2%); syncope (2.1%); heart failure (2.0); severe/resistant heart failure (2.0%); myocardial infarction (1.7%); vomiting (1.6%); headache (1.2%); abnormal kidney function (1.2%); abnormal chest pain (1.1%); diarrhea (1.1%). Isolated cases of death have been reported with the use of ramipril that appear to be related to hypotension (including first dose effects), but many of these are difficult to differentiate from progression of underlying disease (see WARNINGS – Hypertension). Discontinuation of therapy due to adverse reactions was required in 368/1,004 post-AMI patients taking ramipril (36.7%), compared to 401/982 patients receiving placebo (40.8%).

Clinical Laboratory Test Findings: increased creatinine; increases in blood urea nitrogen (BUN), decreases in hemoglobin or hematocrit; hypotension; elevations of liver enzymes, serum bilirubin, uric acid, blood glucose; proteinuria and significant increases in serum potassium.

DOSAGE AND ADMINISTRATION

Essential Hypertension: Dosage of ALTA^{CE} (ramipril) must be individualized. Initiation of therapy requires consideration of recent antihypertensive drug treatment, the extent of blood pressure elevation and salt restriction. The dosage of other antihypertensive agents being used with ALTA^{CE} may need to be adjusted.

Monotherapy: The recommended initial dosage of ALTA^{CE} in patients not on diuretics is 2.5 mg once daily. Dosage should be adjusted according to blood pressure response, generally, at intervals of at least two weeks. The usual dose range is 2.5 to 10 mg once daily. A daily dose of 20 mg should not be exceeded.

In some patients treated once daily, the antihypertensive effect may diminish towards the end of the dosing interval. This can be evaluated by measuring blood pressure just prior to dosing to determine whether satisfactory control is being maintained for 24 hours. If it is not, either twice daily administration with the same total daily dose, or an increase in dose should be considered. If blood pressure is not controlled with ALTA^{CE} alone, a diuretic may be added. After the addition of a diuretic, it may be possible to reduce the dose of ALTA^{CE}.

Concomitant Diuretic Therapy: Symptomatic hypotension occasionally may occur following the initial dose of ALTA^{CE} and is more likely in patients who are currently being treated with a diuretic. The diuretic should, if possible, be discontinued for two

to three days before beginning therapy with ALTA^{CE} to reduce the likelihood of hypotension (see WARNINGS). If the diuretic cannot be discontinued, an initial dose of 1.25 mg of ALTA^{CE} should be used with careful medical supervision for several hours and until blood pressure has stabilized. The dosage of ALTA^{CE} should subsequently be titrated (as described above) to the optimal response.

Use in Renal Impairment: For patients with a creatinine clearance below 40 mL/min/1.73 m² (serum creatinine above 2.5 mg/dL), the recommended initial dose is 1.25 mg of ALTA^{CE} once daily. Dosage may be titrated upward until blood pressure is controlled or to a maximum total daily dose of 5 mg. In patients with severe renal impairment (creatinine clearance below 10 mL/min/1.73 m²) the maximum total daily dose of 2.5 mg of ALTA^{CE} should not be exceeded.

Treatment Following Acute Myocardial Infarction: Initiation of therapy requires consideration of concomitant medication and baseline blood pressure and should be instituted under close medical supervision, usually in a hospital, three to ten days following an acute myocardial infarction in haemodynamically stable patients with clinical signs of heart failure. The recommended initial dosage of ALTA^{CE} is 2.5 mg given twice a day (b.i.d.), one in the morning and one in the evening. If tolerated, and depending on the patient's response, dosage may be increased by doubling at intervals of one to three days. The maximum daily dose of ALTA^{CE} should not exceed 5 mg twice daily (b.i.d.). After the initial dose of ALTA^{CE}, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. If a patient becomes hypotensive at this dosage, it is recommended that the dosage be lowered to 1.25 mg b.i.d. following effective management of the hypotension. (see WARNINGS – Hypotension).

Patients who have been fluid or salt depleted, or treated with diuretics are at an increased risk of hypotension (see WARNINGS – Hypotension). An excessive fall in blood pressure may occur particularly in the following: after the initial dose of ALTA^{CE}; after every first increase of dose of ALTA^{CE}; after the first dose of a concomitant diuretic and/or when increasing the dose of the concomitant diuretic. If appropriate, the dose of any concomitant diuretic should be reduced which may diminish the likelihood of hypotension (see PRECAUTIONS – Drug Interactions). Consideration should be given to reducing the initial dose to 1.25 mg of ALTA^{CE} in these patients.

Use in Renal Impairment: In patients with impaired renal function (creatinine clearance of 20-50 mL/min/1.73 m² body surface area), the initial recommended dosage is generally 1.25 mg of ALTA^{CE} once daily. This dosage may be increased with caution up to 1.25 mg of ALTA^{CE} twice daily, depending upon clinical response and tolerability.

Insufficient data is available concerning the use of ramipril following acute myocardial infarction in patients with heart failure and severe renal failure. (see ACTION AND CLINICAL PHARMACOLOGY – Pharmacokinetics and Metabolism, PRECAUTIONS – Renal Impairment).

Use in Hepatic Impairment: Insufficient data is available concerning the use of ramipril following acute myocardial infarction in patients with heart failure and hepatic dysfunction. Dose reduction and careful monitoring of these patients is required (see ACTIONS AND CLINICAL PHARMACOLOGY – Pharmacokinetics and Metabolism, PRECAUTIONS – Patients with Impaired Liver Function).

Management of Patients at Increased Risk of Cardiovascular Events: Recommended initial dose: 2.5 mg of ALTA^{CE} once daily. Depending on the tolerability, the dose is gradually increased. It is recommended to double the dose after one week of treatment and – after another three weeks – to increase it to 10 mg. Usual maintenance dose: 10 mg of ALTA^{CE} daily (see ACTION AND CLINICAL PHARMACOLOGY, WARNINGS and PRECAUTIONS). Dosage recommendations for special risk groups such as patients with renal or hepatic impairment, or at an increased risk of hypotension (fluid or salt depletion, treated with diuretics) are to be followed as previously described (see WARNINGS and PRECAUTIONS).

DOSAGE FORM

a) Composition

ALTA^{CE} (ramipril) capsules 1.25 mg, 2.5 mg, and 10.0 mg contain the medicinal ingredient ramipril in quantities of 1.25 mg, 2.5 mg, 5.0 mg, and 10.0 mg respectively. The qualitative formulation for all potencies of ALTA^{CE} is: ramipril, pre-gelatinized starch NF (as filler, gliding agent and disintegration agent) and empty gelatin capsules. Empty gelatin capsules for all potencies of ALTA^{CE} are composed of gelatin and coloring agents specific to each potency (see below).

POTENCY	CAP	BODY
1.25 mg	Yellow iron oxide Titanium dioxide	Titanium dioxide
2.5 mg	Yellow iron oxide FD & C red no. 3 Titanium dioxide	Titanium dioxide
5.0 mg	FD & C blue no. 2 FD & C red no. 3 Titanium dioxide	Titanium dioxide
10.0 mg	FD & C blue no. 2 FD & C red no. 3 Black iron oxide Titanium dioxide	Titanium dioxide

b) Stability and storage recommendations

Store ALTA^{CE} (ramipril) in original container at room temperature, below 25°C and not beyond the date indicated on the container.

AVAILABILITY: No. 4 hard gelatin capsules:

- 1.25 mg (white/yellow);
- 2.5 mg (white/orange);
- 5.0 mg (white/red);
- 10.0 mg (white/blue).

ALTA^{CE} capsules 1.25 mg, 2.5 mg, 5.0 mg and 10.0 mg are packaged in cartons of 30 (2 x 15 blister-packed) capsules. Bottles of 100 capsules and 500 capsules also available.

Product monograph available upon request.

References:

1. ALTA^{CE} Product Monograph. 2. The Heart Outcomes Prevention Evaluation Study Investigators (HOPE) Trial. Effects of an angiotensin-converting-enzyme inhibitor, ramipril, on cardiovascular events in high-risk patients. *N Engl J Med* 2000;342(3):145-53.



LIPITOR[®]

atorvastatin calcium
tablets

power you can trust[™]

LIPITOR[®]

(atorvastatin calcium)
10 mg, 20 mg, 40 mg and 80 mg tablets

THERAPEUTIC CLASSIFICATION: Lipid Metabolism Regulator

ACTIONS AND CLINICAL PHARMACOLOGY

Please refer to the Product Monograph for complete ACTION and CLINICAL PHARMACOLOGY information.

Clinical Studies

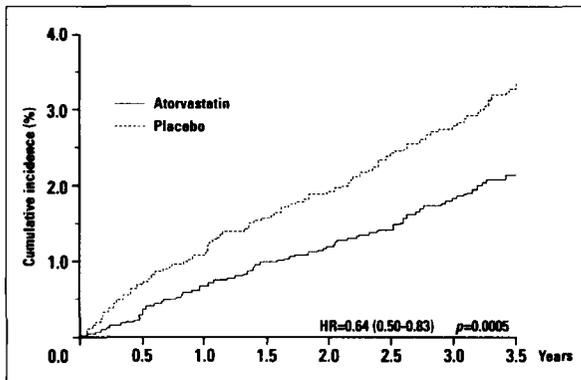
Prevention of Cardiovascular Disease

In the Anglo-Scandinavian Cardiac Outcomes Trial (ASCOT), the effect of LIPITOR (atorvastatin calcium) on fatal and non-fatal coronary heart disease was assessed in 10,305 hypertensive patients 40-80 years of age (mean of 63 years), without a previous myocardial infarction and with TC levels ≤ 6.5 mmol/L. Additionally all patients had at least 3 of the following cardiovascular risk factors: male gender (81.1%), age >55 years (84.5%), smoking (33.2%), diabetes (24.3%), history of CHD in a first-degree relative (26%), TC:HDL > 6 (14.3%), peripheral vascular disease (5.1%), left ventricular hypertrophy (14.4%), prior cerebrovascular event (9.8%), specific ECG abnormality (14.3%), proteinuria/albuminuria (62.4%). In this double-blind, placebo-controlled study, patients were treated with anti-hypertensive therapy (Goal BP <140/90 mm Hg for non-diabetic patients, <130/80 mm Hg for diabetic patients) and allocated to either LIPITOR 10 mg daily ($n=5168$) or placebo ($n=5137$), using a covariate adaptive method which took into account the distribution of nine baseline characteristics of patients already enrolled and minimized the imbalance of those characteristics across the groups. Patients were followed for a median duration of 3.3 years.

The effect of 10 mg/day of LIPITOR on lipid levels was similar to that seen in previous clinical trials.

LIPITOR significantly reduced the rate of coronary events [either fatal coronary heart disease (46 events in the placebo group vs 40 events in the LIPITOR group) or nonfatal MI (108 events in the placebo group vs 60 events in the LIPITOR group)] with an absolute risk reduction of 1.1% and a relative risk reduction of 36% (based on incidences of 1.9% for LIPITOR vs 3.0% for placebo), $p=0.0005$ (see figure 1). This risk reduction yields a Number Needed to Treat of 311 patients per year. The risk reduction was consistent regardless of age, smoking status, obesity or presence of renal dysfunction. The effect of LIPITOR was seen regardless of baseline LDL levels. Due to the small number of events, results for women were inconclusive.

Figure 1: Effect of LIPITOR 10 mg/day on Cumulative Incidence of Nonfatal Myocardial Infarction or Coronary Heart Disease Death (in ASCOT-LIA)



INDICATIONS AND CLINICAL USE

Hypercholesterolemia

LIPITOR (atorvastatin calcium) is indicated as an adjunct to lifestyle changes, including diet, (at least equivalent to the Adult Treatment Panel III (ATP III) TLC diet), for the reduction of elevated total cholesterol, (total-C), LDL-C, TG and apolipoprotein B (apo B) in hyperlipidemic and dyslipidemic conditions, when response to diet and other nonpharmacological measures alone has been inadequate, including:

- Primary hypercholesterolemia (Type Ia);
- Combined (mixed) hyperlipidemia (Type IIb), including familial combined hyperlipidemia, regardless of whether cholesterol or triglycerides are the lipid abnormality of concern;
- Dysbetalipoproteinemia (Type III);
- Hypertriglyceridemia (Type IV);
- Familial hypercholesterolemia (homozygous and heterozygous). For homozygous familial hypercholesterolemia, LIPITOR should be used as an adjunct to treatments such as LDL apheresis, or as monotherapy if such treatments are not available.

LIPITOR also raises HDL cholesterol and therefore lowers the LDL-C:HDL-C and total-C:HDL-C ratios in patients with primary hypercholesterolemia and combined (mixed) hyperlipidemia (Fredrickson Type IIa and IIb dyslipidemia). In pooled data from 24 controlled clinical trials, LIPITOR raised HDL-C levels 5%-7% in primary hypercholesterolemia (type IIa) patients and 10%-15% in mixed (type IIb) dyslipidemic patients.

In clinical trials, LIPITOR (10 to 80 mg/day) significantly improved lipid profiles in patients with a wide variety of hyperlipidemic and dyslipidemic conditions. In 2 dose-response studies in mildly to moderately hyperlipidemic patients (Fredrickson Types IIa and IIb), LIPITOR reduced the levels of total cholesterol (29-45%), LDL-C (39-60%), apo B (32-50%), TG (19-37%), and increased high density lipoprotein cholesterol (HDL-C) levels (5-9%). Comparable responses were achieved in patients with heterozygous familial hypercholesterolemia, non-familial forms of hypercholesterolemia, combined hyperlipidemia, including familial combined hyperlipidemia and patients with non-insulin dependent diabetes mellitus. In patients with hypertriglyceridemia (Type IV), LIPITOR (10 to 80 mg daily) reduced TG (25-56%) and LDL-C levels (23-40%). LIPITOR has not been studied in conditions where the major abnormality is elevation of chylomicrons (TG levels > 11 mmol/L), i.e., types I and V.

In an open-label study in patients with dysbetalipoproteinemia (Type III), LIPITOR (10 to 80 mg daily) reduced total-C (40-57%), TG (40-56%) and IDL-C + VLDL-C levels (34-58%).

In an open label study in patients with homozygous familial hypercholesterolemia (FH) LIPITOR (10 to 80 mg daily) reduced mean LDL-C levels (22%). In a pilot study, LIPITOR 80 mg/day showed a mean LDL-C lowering of 30% for patients not on plasmapheresis and of 31% for patients who continued plasmapheresis. A mean LDL-C lowering of 35% was observed in receptor defective patients and of 19% in receptor negative patients (see PHARMACOLOGY, Clinical Studies).

Prior to initiating therapy with LIPITOR, secondary causes should be excluded for elevations in plasma lipid levels (e.g. poorly controlled diabetes mellitus, hypothyroidism, nephrotic syndrome, dysproteinemias, obstructive liver disease, and alcoholism), and a lipid profile performed to measure total cholesterol, LDL-C, HDL-C, and TG. For patients with TG <4.52 mmol/L (<400 mg/dL), LDL-C can be estimated using the following equation:

$$\text{LDL-C (mmol/L)} = \text{total-C} - \{0.37 \times (\text{TG} + \text{HDL-C})\}$$

$$\text{LDL-C (mg/dL)} = \text{total-C} - \{0.2 \times (\text{TG} + \text{HDL-C})\}$$

For patients with TG levels >4.52 mmol/L (>400 mg/dL), this equation is less accurate and LDL-C concentrations should be measured directly or by ultracentrifugation.

1. Friedewald WT, et al. *Clin Chem* 1972;18(6):489-502.

Patients with high or very high triglyceride levels, i.e. > 2.2 mmol/L (200 mg/dL) or > 5.6 mmol/L (500 mg/dL), respectively, may require triglyceride-lowering therapy (fenofibrate, bezafibrate or nicotinic acid) alone or in combination with LIPITOR.

In general, combination therapy with fibrates must be undertaken cautiously and only after risk-benefit analysis (see WARNINGS, Muscle Effects, PRECAUTIONS, Pharmacokinetic Interaction Studies and Potential Drug Interactions).

Elevated serum triglycerides are most often observed in patients with the metabolic syndrome (abdominal obesity, atherogenic dyslipidemia [elevated triglycerides, small dense LDL particles and low HDL-cholesterol], insulin resistance with or without glucose intolerance, raised blood pressure and prothrombotic and proinflammatory states).

(For the treatment of specific dyslipidemias refer to the Report of the Canadian Working Group on Hypercholesterolemia and Other Dyslipidemias or to the US NCEP Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III)).

When drugs are prescribed attention to therapeutic lifestyle changes (reduced intake of saturated fats and cholesterol, weight reduction, increased physical activity, ingestion of soluble fibers) should always be maintained and reinforced.

Prevention of Cardiovascular Disease

LIPITOR is indicated to reduce the risk of myocardial infarction in adult hypertensive patients without clinically evident coronary heart disease, but with at least three additional risk factors for coronary heart disease such as age ≥ 55 years, male sex, smoking, type 2 diabetes, left ventricular hypertrophy, other specified abnormalities on ECG, microalbuminuria or proteinuria, ratio of plasma total cholesterol to HDL-cholesterol ≥ 6 , or premature family history of coronary heart disease.

The Atorvastatin Versus Revascularization Treatments (AVERT) study examined the effect of intensive lipid-lowering in patients with stable coronary artery disease and LDL-C at least 3.0 mmol/L in patients referred for percutaneous transluminal coronary angioplasty (PTCA). Patients were randomised for 18 months to LIPITOR 80 mg daily or to PTCA with usual medical care which could include lipid metabolism regulators. The results of the AVERT study should be considered as exploratory since several limitations may affect its design and conduct. In the medical-treated group with LIPITOR there was a trend for a reduced incidence of ischemic events and a delayed time to first ischemic event. The results also suggest that intensive treatment to target LDL-C levels with LIPITOR is **additive and complementary** to angioplasty and would benefit patients referred for this procedure.

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal (see WARNINGS).

Pregnancy and lactation (see PRECAUTIONS).

WARNINGS

Pharmacokinetic Interactions

The use of HMG-CoA reductase inhibitors has been associated with severe myopathy, including rhabdomyolysis, which may be more frequent when they are co-administered with drugs that inhibit the cytochrome P-450 enzyme system. Atorvastatin is metabolized by cytochrome P-450 isoform 3A4 and as such may interact with agents that inhibit this enzyme. (See WARNINGS, Muscle effects and PRECAUTIONS, Drug Interactions and Cytochrome P-450-mediated Interactions).

Hepatic Effects

In clinical trials, persistent increases in serum transaminases greater than three times the upper limit of normal occurred in <1% of patients who received LIPITOR. When the dosage of LIPITOR was reduced, or when drug treatment was interrupted or discontinued, serum transaminase levels returned to pretreatment levels. The increases were generally not associated with jaundice or other clinical signs or symptoms. Most patients continued treatment with a reduced dose of LIPITOR without clinical sequelae.

Liver function tests should be performed before the initiation of treatment, and periodically thereafter. Special attention should be paid to patients who develop elevated serum transaminase levels, and in these patients measurements should be repeated promptly and then performed more frequently.

If increases in alanine aminotransferase (ALT) or aspartate aminotransferase (AST) show evidence of progression, particularly if they rise to greater than 3 times the upper limit of normal and are persistent, the dosage should be reduced or the drug discontinued.

LIPITOR should be used with caution in patients who consume substantial quantities of alcohol and/or have a past history of liver disease. Active liver disease or unexplained transaminase elevations are contraindications to the use of LIPITOR; if such a condition should develop during therapy, the drug should be discontinued.

Muscle Effects

Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatinine phosphokinase (CPK) values to greater than ten times the upper limit of normal, should be considered in any patient with diffuse myalgia, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. LIPITOR therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. The risk of myopathy and rhabdomyolysis during treatment with HMG-CoA reductase inhibitors is increased with concurrent administration of cyclosporin, fibrin acid derivatives, erythromycin, clarithromycin, niacin (nicotinic acid), azole antifungals or nefazodone. As there is no experience to date with the use of LIPITOR given concurrently with these drugs, with the exception of pharmacokinetic studies conducted in healthy subjects with erythromycin and clarithromycin, the benefits and risks of such combination therapy should be carefully considered (see PRECAUTIONS, Pharmacokinetic Interaction Studies and Potential Drug Interactions).

Rhabdomyolysis has been reported in very rare cases with LIPITOR (see PRECAUTIONS, Drug Interactions).

Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has also been reported with HMG-CoA reductase inhibitors. LIPITOR therapy should be temporarily withheld or discontinued in any patient with an acute serious condition suggestive of a myopathy or having a risk factor predisposing to the development of renal failure secondary to rhabdomyolysis (such as severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders, and uncontrolled seizures).

PRECAUTIONS

General

Before instituting therapy with LIPITOR (atorvastatin calcium), an attempt should be made to control elevated serum lipoprotein levels with appropriate diet, exercise, and weight reduction in overweight patients, and to treat other underlying medical problems (see INDICATIONS AND CLINICAL USE). Patients should be advised to inform subsequent physicians of the prior use of LIPITOR or any other lipid-lowering agents.

Effect on the Lens

Current long-term data from clinical trials do not indicate an adverse effect of atorvastatin on the human lens.

Effect on Ubiquinone (CoQ₁₀) Levels

Significant decreases in circulating ubiquinone levels in patients treated with atorvastatin and other statins have been observed. The clinical significance of a potential long-term statin-induced deficiency of ubiquinone has not been established. It has been reported that a decrease in myocardial ubiquinone levels could lead to impaired cardiac function in patients with borderline congestive heart failure.

Effect on Lipoprotein (a)

In some patients, the beneficial effect of lowered total cholesterol and LDL-C levels may be partly blunted by a concomitant increase in Lp(a) lipoprotein concentrations. Present knowledge suggests the importance of high Lp(a) levels as an emerging risk factor for coronary heart disease. It is thus desirable to maintain and reinforce lifestyle changes in high risk patients placed on atorvastatin therapy.

Hypersensitivity

An apparent hypersensitivity syndrome has been reported with other HMG-CoA reductase inhibitors which has included 1 or more of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, eosinophilia, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome. Although to date hypersensitivity syndrome has not been described as such, LIPITOR should be discontinued if hypersensitivity is suspected.

Use in Pregnancy

LIPITOR is contraindicated during pregnancy (see CONTRAINDICATIONS).

Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since

HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause harm to the fetus when administered to pregnant women.

There are no data on the use of LIPITOR during pregnancy. LIPITOR should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking LIPITOR, the drug should be discontinued and the patient apprised of the potential risk to the fetus.

Nursing Mothers

In rats, milk concentrations of atorvastatin are similar to those in plasma. It is not known whether this drug is excreted in human milk. Because of the potential for adverse reactions in nursing infants, women taking LIPITOR should not breast-feed (see CONTRAINDICATIONS).

Pediatric Use

Treatment experience in a pediatric population is limited to doses of LIPITOR up to 80 mg/day for 1 year in 8 patients with homozygous familial hypercholesterolemia. No clinical or biochemical abnormalities were reported in these patients.

Geriatric Use

Treatment experience in adults 70 years or older (N=221) with doses of LIPITOR up to 80 mg/day has demonstrated that the safety and effectiveness of atorvastatin in this population was similar to that of patients <70 years of age. Pharmacokinetic evaluation of atorvastatin in subjects over the age of 65 years indicates an increased AUC. As a precautionary measure, the lowest dose should be administered initially.

Renal Insufficiency

Plasma concentrations and LDL-C lowering efficacy of LIPITOR was shown to be similar in patients with moderate renal insufficiency compared with patients with normal renal function. However, since several cases of rhabdomyolysis have been reported in patients with a history of renal insufficiency of unknown severity, as a precautionary measure and pending further experience in renal disease, the lowest dose (10 mg/day) of LIPITOR should be used in these patients. Similar precautions apply in patients with severe renal insufficiency [creatinine clearance <30 mL/min (<0.5 mL/sec)]; the lowest dosage should be used and implemented cautiously (see WARNINGS, Muscle Effects; PRECAUTIONS, Drug Interactions). Refer also to DOSAGE AND ADMINISTRATION.

Endocrine Function

HMG-CoA reductase inhibitors interfere with cholesterol synthesis and as such might theoretically blunt adrenal and/or gonadal steroid production. Clinical studies with atorvastatin and other HMG-CoA reductase inhibitors have suggested that these agents do not reduce plasma cortisol concentration or impair adrenal reserve and do not reduce basal plasma testosterone concentration. However, the effects of HMG-CoA reductase inhibitors on male fertility have not been studied in adequate numbers of patients. The effects, if any, on the pituitary-gonadal axis in premenopausal women are unknown.

Patients treated with atorvastatin who develop clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients receiving other drugs (e.g., ketoconazole, spironolactone or cimetidine) that may decrease the levels of endogenous steroid hormones.

Pharmacokinetic Interaction Studies and Potential Drug Interactions

Pharmacokinetic interaction studies conducted with drugs in healthy subjects may not detect the possibility of a potential drug interaction in some patients due to differences in underlying diseases and use of concomitant medications (see also Geriatric Use; Renal Insufficiency; Patients with Severe Hypercholesterolemia).

Concomitant Therapy with Other Lipid Metabolism Regulators: Combined drug therapy should be approached with caution as information from controlled studies is limited.

Bile Acid Sequestrants:

Patients with mild to moderate hypercholesterolemia: LDL-C reduction was greater when LIPITOR 10 mg and colestipol 20 g were coadministered (-45%) than when either drug was administered alone (-35% for LIPITOR and -22% for colestipol).

Patients with severe hypercholesterolemia: LDL-C reduction was similar (-53%) when LIPITOR 40 mg and colestipol 20 g were coadministered when compared to that with LIPITOR 80 mg alone. Plasma concentration of atorvastatin was lower (approximately 26%) when LIPITOR 40 mg plus colestipol 20 g were coadministered compared with LIPITOR 40 mg alone. However, the combination drug therapy was less effective in lowering the triglycerides than LIPITOR monotherapy in both types of hypercholesterolemic patients.

When LIPITOR is used concurrently with atorvastatin or any other resin, an interval of at least 2 hours should be maintained between the two drugs, since the absorption of LIPITOR may be impaired by the resin.

Fibric Acid Derivatives (Gemfibrozil, Fenofibrate, Bezafibrate) and Niacin (Nicotinic Acid): Although there is limited experience with the use of LIPITOR given concurrently with fibric acid derivatives and niacin, the benefits and risks of such combined therapy should be carefully considered. The risk of myopathy during treatment with other drugs in this class, including atorvastatin, is increased with concurrent administration (see WARNINGS, Muscle Effects).

Coumarin Anticoagulants: LIPITOR had no clinically significant effect on prothrombin time when administered to patients receiving chronic warfarin therapy.

Digoxin: In healthy subjects, digoxin pharmacokinetics at steady-state were not significantly altered by coadministration of digoxin 0.25 mg and LIPITOR 10 mg daily. However, digoxin steady-state concentrations increased approximately 20% following coadministration of digoxin 0.25 mg and LIPITOR 80 mg daily. Patients taking digoxin should be monitored appropriately.

Antihypertensive agents (amlodipine): In clinical studies, LIPITOR was used concomitantly with antihypertensive agents without evidence to date of clinically significant adverse interactions. In healthy subjects, atorvastatin pharmacokinetics were not altered by the coadministration of LIPITOR 80 mg and amlodipine 10 mg at steady state.

(quinapril): In a randomized, open-label study in healthy subjects, steady-state quinapril dosing (80 mg QD) did not significantly affect the pharmacokinetic profile of atorvastatin tablets (10 mg QD).

Oral Contraceptives and Hormone Replacement Therapy: Coadministration of LIPITOR with an oral contraceptive, containing 1 mg norethindrone and 35 µg ethinyl estradiol, increased plasma concentrations (AUC levels) of norethindrone and ethinyl estradiol by approximately 30% and 20%, respectively. These increases should be considered when selecting an oral contraceptive. In clinical studies, LIPITOR was used concomitantly with estrogen replacement therapy without evidence to date of clinically significant adverse interactions.

Antacids: Administration of aluminum and magnesium based antacids, such as Maalox® TC Suspension, with LIPITOR decreased plasma concentrations of LIPITOR by approximately 35%. LDL-C reduction was not altered but the triglyceride-lowering effect of LIPITOR may be affected.

Cimetidine: Administration of cimetidine with LIPITOR did not alter plasma concentrations or LDL-C lowering efficacy of LIPITOR, however, the triglyceride-lowering effect of LIPITOR was reduced from 34% to 26%.

Cytochrome P-450-mediated Interactions: Atorvastatin is metabolized by the cytochrome P-450 isoenzyme, CYP 3A4. Erythromycin, a CYP 3A4 inhibitor, increased atorvastatin plasma levels by 40%. Coadministration of CYP 3A4 inhibitors, such as grapefruit juice, some macrolide antibiotics (i.e., erythromycin, clarithromycin), immunosuppressants (cyclosporine), azole antifungal agents (i.e., itraconazole, ketoconazole), protease inhibitors, or the antidepressant, nefazodone, may have the potential to increase plasma concentrations of HMG-CoA reductase inhibitors, including LIPITOR. Caution should thus be exercised with concomitant use of these agents (see WARNINGS, Pharmacokinetic Interactions, Muscle Effects; PRECAUTIONS, Renal Insufficiency and Endocrine Function; DOSAGE AND ADMINISTRATION).

In healthy subjects, coadministration of maximum doses of both atorvastatin (80 mg) and terfenadine (120 mg), a CYP 3A4 substrate, was shown to produce a modest increase in terfenadine AUC. The QTc interval remained unchanged. However, since an interaction between these two drugs cannot be excluded in patients with predisposing factors for arrhythmia, (e.g. preexisting prolonged QT interval, severe coronary artery disease, hypokalemia), caution should be exercised when these agents are coadministered (see WARNINGS, Pharmacokinetic Interactions; DOSAGE AND ADMINISTRATION).

Antipyrine: Antipyrine was used as a non-specific model for drugs metabolized by the microsomal hepatic enzyme system (cytochrome P-450 system). LIPITOR had no effect on the pharmacokinetics of antipyrine, thus interactions with other drugs metabolized via the same cytochrome isozymes are not expected.

Macrolide Antibiotics (azithromycin, clarithromycin, erythromycin): In healthy adults, coadministration of LIPITOR (10 mg QD) and azithromycin (500 mg QD) did not significantly alter the plasma concentrations of atorvastatin. However, coadministration of atorvastatin (10 mg QD) with erythromycin (500 mg QID) or clarithromycin (500 mg BID), which are both CYP 3A4 inhibitors, increased plasma concentrations of atorvastatin approximately 40% and 80%, respectively (see WARNINGS, Muscle Effects).

Protease Inhibitors (nelfinavir mesylate): In healthy adults, coadministration of nelfinavir mesylate (1250 mg BID), a known CYP 3A4 inhibitor, and atorvastatin (10 mg QD) resulted in increased plasma concentrations of atorvastatin. AUC and C_{max} of atorvastatin were increased by 74% and 122% respectively.

Patients with Severe Hypercholesterolemia: Higher drug dosages (80 mg/day) required for some patients with severe hypercholesterolemia (including familial hypercholesterolemia) are associated with increased plasma levels of atorvastatin. Caution should be exercised in such patients who are also severely renally impaired, elderly, or are concomitantly being administered digoxin or CYP 3A4 inhibitors (see WARNINGS, Pharmacokinetic Interactions, Muscle Effects; PRECAUTIONS, Drug Interactions; DOSAGE AND ADMINISTRATION).

Drug/Laboratory Test Interactions

LIPITOR may elevate serum transaminase and creatinine phosphokinase levels (from skeletal muscle). In the differential diagnosis of chest pain in a patient on therapy with LIPITOR, cardiac and noncardiac fractions of these enzymes should be determined.

ADVERSE REACTIONS

LIPITOR is generally well-tolerated. Adverse reactions have usually been mild and transient. In controlled clinical studies (placebo-controlled and active-controlled comparative studies with other lipid lowering agents) involving 2502 patients, <2% of patients were discontinued due to adverse experiences attributable to LIPITOR. Of these 2502 patients, 1721 were treated for at least 6 months and 1253 for 1 year or more.

Adverse experiences occurring at an incidence ≥1% in patients participating in placebo-controlled clinical studies of LIPITOR and reported to be possibly, probably or definitely drug related are shown in Table 1 below:

TABLE 1. Associated Adverse Events Reported in ≥1% of Patients in Placebo-Controlled Clinical Trials

	Placebo % (n=270)	LIPITOR % (n=1122)
GASTROINTESTINAL		
Constipation	1	1
Diarrhea	1	1
Dyspepsia	2	1
Flatulence	2	1
Nausea	0	1
NERVOUS SYSTEM		
Headache	2	1
MISCELLANEOUS		
Pain	<1	1
Myalgia	1	1
Asthenia	<1	1

The following additional adverse events were reported in clinical trials; not all events listed below have been associated with a causal relationship to LIPITOR therapy: Muscle cramps, myositis, myopathy, paresthesia, peripheral neuropathy, pancreatitis, hepatitis, cholestatic jaundice, anorexia, vomiting, alopecia, pruritus, rash, impotence, hyperglycemia, and hypoglycemia.

Post-marketing experience: Very rare reports: severe myopathy with or without rhabdomyolysis (see WARNINGS, Muscle Effects; PRECAUTIONS, Renal Insufficiency and Drug Interactions). Isolated reports: thrombocytopenia, arthralgia and allergic reactions including urticaria, angioneurotic edema, anaphylaxis and bullous rashes (including erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis). These may have no causal relationship to atorvastatin.

Ophthalmologic observations: see PRECAUTIONS.

Laboratory Tests: Increases in serum transaminase levels have been noted in clinical trials (see WARNINGS).

DOSAGE AND ADMINISTRATION

Patients should be placed on a standard cholesterol-lowering diet [at least equivalent to the Adult Treatment Panel III (ATP III) TLC diet] before receiving LIPITOR, and should continue on this diet during treatment with LIPITOR. If appropriate, a program of weight control and physical exercise should be implemented.

Primary Hypercholesterolemia and Combined (Mixed) Dyslipidemia, Including Familial Combined Hyperlipidemia

The recommended starting dose of LIPITOR is 10 or 20 mg once daily. Patients who require a large reduction in LDL-C (more than 45%) may be started at 40 mg once daily. The dosage range of LIPITOR is 10 to 80 mg once daily. Doses can be given at any time of the day, with or without food, and should preferably be given in the evening. Doses should be individualized according to the level of risk; the baseline LDL-C and/or TG levels; the desired LDL-C and/or TG target; and/or TC/HDL-C target (see the Detection and Management of Hypercholesterolemia, Working Group on Hypercholesterolemia and other Dyslipidemias [Canada] and/or the US National Cholesterol Education Program [NCEP Adult Treatment Panel III]); the goal of therapy and the patient's response. A significant therapeutic response is evident within 2 weeks, and the maximum response is usually achieved within 2-4 weeks. The response is maintained during chronic therapy. Adjustments of dosage, if necessary, should be made at intervals of 2-4 weeks. The maximum dose is 80 mg/day.

Lipid levels should be monitored periodically and, if necessary, the dose of LIPITOR adjusted based on target lipid levels recommended by guidelines.

The following reductions in total cholesterol and LDL-C levels have been observed in 2 dose-response studies, and may serve as a guide to treatment of patients with mild to moderate hypercholesterolemia:

TABLE 2. Dose-Response in Patients With Mild to Moderate Hypercholesterolemia (Mean Percent Change from Baseline)

Lipid Parameter	LIPITOR Dose (mg/day)			
	10 (N=22)	20 (N=20)	40 (N=21)	80 (N=23)
Total-C: 7.1 mmol/L (273 mg/dL)*	-29	-33	-37	-45
LDL-C: 4.9 mmol/L (190 mg/dL)*	-39	-43	-50	-60

* Results are pooled from 2 dose-response studies.

† Mean baseline values.

Severe Dyslipidemias

In patients with severe dyslipidemias, including homozygous and heterozygous familial hypercholesterolemia and dysbetalipoproteinemia (Type III), higher dosages (up to 80 mg/day) may be required (see WARNINGS, Pharmacokinetic Interactions, Muscle Effects; PRECAUTIONS, Drug Interactions).

Concomitant Therapy

See PRECAUTIONS, Drug Interactions.

Dosage in Patients With Renal Insufficiency

See PRECAUTIONS.

AVAILABILITY OF DOSAGE FORMS

LIPITOR (atorvastatin calcium) is available in dosage strengths of 10 mg, 20 mg, 40 mg and 80 mg atorvastatin per tablet.

10 mg: White, elliptical, film-coated tablet, coded "10" on one side and "PD 155" on the other. Available in bottles of 90 tablets.

20 mg: White, elliptical, film-coated tablet, coded "20" on one side and "PD 156" on the other. Available in bottles of 90 tablets.

40 mg: White, elliptical, film-coated tablet, coded "40" on one side and "PD 157" on the other. Available in bottles of 90 tablets.

80 mg: White, elliptical, film-coated tablet, coded "80" on one side and "PD 158" on the other. Available in blisters of 30 tablets (3 strips X 10).

For a copy of the Product Monograph or full Prescribing Information, please contact:



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Ropinirole (as ropinirole hydrochloride)

TABLETS: 0.25 mg, 1.0 mg, 2.0 mg, 5.0 mg

THERAPEUTIC CLASSIFICATION: AntiParkinsonian Agent / Dopamine Agonist
INDICATIONS AND CLINICAL USE: REQUIP[®] (ropinirole hydrochloride) is indicated in the treatment of the signs and symptoms of idiopathic Parkinson's disease. REQUIP[®] can be used both as early therapy, without concomitant levodopa and as an adjunct to levodopa. Three year and five year active-comparator controlled clinical trials have been conducted.

CONTRAINDICATIONS: REQUIP[®] (ropinirole hydrochloride) is contraindicated in patients with a known hypersensitivity to ropinirole hydrochloride or the excipients of the drug product.

WARNINGS: Sudden Onset of Sleep – Patients receiving treatment with REQUIP[®] (ropinirole hydrochloride), and other dopaminergic agents have reported suddenly falling asleep while engaged in activities of daily living, including operating a motor vehicle, which has sometimes resulted in accidents. Although some of the patients reported somnolence while on REQUIP[®], others perceived that they had no warning signs, such as excessive drowsiness, and believed that they were alert immediately prior to the event. Physicians should alert patients of the reported cases of sudden onset of sleep, bearing in mind that these events are NOT limited to initiation of therapy. Patients should also be advised that sudden onset of sleep has occurred without warning signs. If drowsiness or sudden onset of sleep should occur, patients should immediately contact their physician. Until further information is available on the management of this unpredictable and serious adverse event, patients should be warned not to drive or engage in other activities where impaired alertness could put themselves and others at risk of serious injury or death (e.g., operating machines). Episodes of falling asleep while engaged in activities of daily living have also been reported in patients taking other dopaminergic agents, therefore, symptoms may not be alleviated by substituting these products. Presently, the precise cause of this event is unknown. It is known that many Parkinson's disease patients experience alterations in sleep architecture, which results in excessive daytime sleepiness or spontaneous dozing, and that dopaminergic agents can also induce sleepiness. There is insufficient information to determine whether this event is associated with REQUIP[®], all dopaminergic agents or Parkinson's disease itself.
Orthostatic Symptoms – Dopamine agonists appear to impair the systemic regulation of blood pressure with resulting orthostatic symptoms of dizziness or lightheadedness, with or without documented hypotension. These symptoms appear to occur especially during dose escalation. Therefore, patients treated with dopamine agonists should be carefully monitored for signs and symptoms of orthostatic hypotension, especially during dose escalation (see DOSAGE and ADMINISTRATION) and should be informed of this risk.
Hallucinations – Early Therapy: In placebo-controlled trials, REQUIP[®] (ropinirole hydrochloride) caused hallucination in 5.1% of patients during early therapy (1.4% in the placebo group). Hallucination was of sufficient severity that it led to discontinuation in 1.3% of patients. The incidence of hallucination was dose-dependent. In a 5-year study comparing REQUIP[®] with levodopa in early Parkinson's patients, the overall incidence of hallucinations was 17.3% (31/179) for patients treated with REQUIP[®] and 5.6% (5/89) for levodopa patients. Hallucinations led to discontinuation of the study treatment in 5.0% of REQUIP[®] and 2.2% of levodopa patients. In a 3-year study comparing REQUIP[®] with another dopamine agonist, the overall incidence of hallucinations was 9.5% (16/168) for patients treated with REQUIP[®] and 9.0% (15/167) for patients receiving active comparator. Hallucinations led to discontinuation of the study treatment in 2.4% of REQUIP[®] patients and 3.0% of comparator patients. Concomitant Selegiline: In a 5-year study, REQUIP[®] patients receiving concomitant selegiline reported a higher incidence of hallucinations (23.5%) than did those without (12.2%); this subpopulation effect was not seen in the L-dopa arm (hallucinations with concomitant selegiline = 2.0% vs hallucinations without selegiline = 8.0%).
Adjunct Therapy: Hallucinations were experienced by 10.1% of patients receiving REQUIP[®] and levodopa, compared to 4.2% receiving placebo and levodopa. Hallucinations were of sufficient severity that it led to discontinuation in 1.9% of patients. The incidence of hallucinations was dose dependent.

PRECAUTIONS: Cardiovascular – Since REQUIP[®] (ropinirole hydrochloride) has not been studied in patients with a history or evidence of significant cardiovascular disease including myocardial infarction, unstable angina, cardiac decompensation, cardiac arrhythmias, vaso-occlusive disease (including cerebral) or cardiomyopathy, it should be used with caution in such patients. There is limited experience with REQUIP[®] in patients treated with antihypertensive and antiarrhythmic agents. Consequently, in such patients, the dose of REQUIP[®] should be titrated with caution.
Orthostatic Symptoms – Orthostatic symptoms of dizziness or lightheadedness as well as somnolence may occur during REQUIP[®] therapy.
Neuroleptic Malignant Syndrome – A symptom complex resembling the neuroleptic malignant syndrome (characterized by elevated temperature, muscular rigidity, altered consciousness, and autonomic instability), with no other obvious etiology, has been reported in association with rapid dose reduction, withdrawal of, or changes in anti-Parkinsonian therapy. A single spontaneous report of a symptom complex resembling the neuroleptic malignant syndrome has been observed in a 66 year old diabetic male patient with Parkinson's disease, who developed fever, muscle stiffness, and drowsiness 8 days after beginning REQUIP[®] treatment. The patient also experienced acute bronchitis, which did not respond to antibiotic treatment. REQUIP[®] was discontinued three days

before the patient died. The reporting physician considered these events to be possibly related to REQUIP[®] treatment. (see DOSAGE AND ADMINISTRATION). A single spontaneous report of severe muscle pain has been reported in a 66 year old male patient around his thigh. The reporting physician considered the event to be probably related to REQUIP[®] treatment.
Retinal Pathology in Rats – In a two year carcinogenicity study in albino Sprague-Dawley rats, retinal atrophy was observed at incidences of 0%, 1.4%, 1.4% and 10% of male rats and 0%, 4.4%, 2.9% and 12.9% of female rats dosed at 0, 1.5, 15 and 50 mg/kg/day respectively. The incidence was significantly higher in both male and female animals dosed at 50 mg/kg/day. The 50 mg/kg/day dose represents a 2.8 fold greater exposure (AUC) and a 13.1 fold greater exposure (C_{max}) to ropinirole in rats than the exposure would be in humans at the maximum recommended dose of 24 mg/day. The relevance of this finding to humans is not known.
Pregnancy – The use of REQUIP[®] during pregnancy is not recommended. REQUIP[®] given to pregnant rats during organogenesis (gestation days 8 through 15) resulted in decreased fetal body weight at 60 mg/kg/day (approximately 3–4 times the AUC at the maximal human dose of 8 mg t.i.d.), increased fetal death at 90 mg/kg/day (approximately 5 times the AUC at the maximal human dose of 8 mg t.i.d.) and digital malformations at 150 mg/kg/day (approximately 8–9 times the AUC at the maximal human dose of 8 mg t.i.d.). These effects occurred at maternally toxic doses. There was no indication of an effect on development of the conceptus at a maternally toxic dose of 20 mg/kg/day in the rabbit. In a perinatal-postnatal study in rats, 10 mg/kg/day of REQUIP[®] (approximately 0.5 – 0.6 times the AUC at the maximal human dose of 8 mg t.i.d.) impaired growth and development of nursing offspring and altered neurological development of female offspring.
Nursing Mothers – Since REQUIP[®] suppresses lactation, it should not be administered to mothers who wish to breast-feed infants. Studies in rats have shown that REQUIP[®] and/or its metabolites cross the placenta and are excreted in breast milk. Consequently, the human fetus and/or neonate may be exposed to dopamine agonist activity.
Use in Women Receiving Estrogen Replacement Therapy – In female patients on long-term treatment with conjugated estrogens, oral clearance was reduced and elimination half-life prolonged compared to patients not receiving estrogens. In patients, already receiving estrogen replacement therapy, REQUIP[®] may be titrated in the recommended manner according to clinical response. However, if estrogen replacement therapy is stopped or introduced during treatment with REQUIP[®], adjustment of the REQUIP[®] dosage may be required.
Pediatric Use – Safety and effectiveness in the pediatric population have not been established.
Renal and Hepatic Impairment – No dosage adjustment is needed in patients with mild to moderate renal impairment (creatinine clearance of 30 to 50 mL/min). Because the use of REQUIP[®] in patients with severe renal impairment or hepatic impairment has not been studied, administration of REQUIP[®] to such patients is not recommended.
Drug Interactions – Psychotropic Drugs: Neuroleptics and other centrally active dopamine antagonists may diminish the effectiveness of REQUIP[®]. Therefore, concomitant use of these products is not recommended. Based on population pharmacokinetic assessment, no interaction was seen between REQUIP[®] and tricyclic antidepressants or benzodiazepines.
Anti-Parkinson Drugs: Based on population pharmacokinetic assessment, there were no interactions between REQUIP[®] and drugs commonly used to treat Parkinson's disease, i.e., selegiline, amantadine, and anticholinergics.
Levodopa: The potential pharmacokinetic interaction of levodopa/carbidopa (100 mg/10 mg b.i.d.) and REQUIP[®] (2 mg t.i.d.) was assessed in levodopa naive (de novo) male and female patients with Parkinson's disease (n=30, mean age 64 years). The rate and extent of availability of REQUIP[®] at steady state were essentially the same with or without levodopa. Similarly, the rate and extent of availability of levodopa, as well as its elimination half-life, were essentially the same in the presence and absence of REQUIP[®].
Inhibitors of CYP1A2: Ciprofloxacin: The effect of ciprofloxacin (500 mg b.i.d.) on the pharmacokinetics of REQUIP[®] (2 mg t.i.d.) was studied in male and female patients with Parkinson's disease (n=12, mean age 55 years). The extent of systemic availability of REQUIP[®] was significantly increased when coadministered with ciprofloxacin (AUC increased by 1.84 fold). Thus, in patients already receiving CYP1A2 inhibitors such as ciprofloxacin, REQUIP[®] therapy may be instituted in the recommended manner and the dose titrated according to clinical response. However, if therapy with a drug known to be an inhibitor of CYP1A2 is stopped or introduced during treatment with REQUIP[®], adjustment of the REQUIP[®] dosage will be required.
Substrates of CYP1A2: Theophylline: The effect of oral theophylline (300 mg b.i.d.) on the pharmacokinetics of REQUIP[®] (2 mg t.i.d.) was studied in male and female patients with Parkinson's disease (n=12, mean age 59 years). There was no marked change in the rate or extent of availability of REQUIP[®] when coadministered with theophylline. Similarly, coadministration of REQUIP[®] with intravenous theophylline (5 mg/kg) did not result in any marked change in the pharmacokinetics of theophylline. It is therefore unlikely that substrates of CYP1A2 would significantly alter the pharmacokinetics of REQUIP[®], and vice-versa.
Digoxin: The effect of REQUIP[®] (2 mg t.i.d.) on the pharmacokinetics of digoxin (0.125–0.25 mg o.d.) was studied in male and female patients with Parkinson's disease (n=10, mean age 72 years). Coadministration at steady state with REQUIP[®] resulted in a 10% decrease in digoxin AUC although mean trough digoxin plasma concentrations were unaltered. However, the effect of higher recommended doses of REQUIP[®] on the pharmacokinetics of digoxin is not known.
Alcohol: No information is available on the potential for interaction between REQUIP[®] and alcohol. As with other centrally active medications, patients should be cautioned against taking REQUIP[®] with alcohol.
Psycho-Motor Performance – (see WARNINGS-Sudden Onset of Sleep).

ADVERSE REACTIONS: Adverse Reactions Associated with Discontinuation of Treatment – Of 1599 patients who received REQUIP[®] (ropinirole hydrochloride) during the premarketing clinical trials, 17.1% in

early-therapy studies and 17.3% in adjunct-therapy studies discontinued treatment due to adverse reactions. The events resulting in discontinuation of REQUIP[®] in 1% or more of patients were as follows: **Early therapy:** nausea (6.4%), dizziness (3.6%), aggravated Parkinson's disease (1.3%), hallucination (1.3%), headache (1.3%), somnolence (1.3%) and vomiting (1.3%). **Adjunct therapy:** dizziness (2.9%), dyskinesia (2.4%), confusion (2.4%), vomiting (2.4%), hallucination (1.9%), nausea (1.9%), anxiety (1.9%), and increased sweating (1.4%). Patients over 75 years of age (n=130) showed slightly higher incidences of withdrawal due to hallucination, confusion and dizziness than patients less than 75 years of age. **Most Frequent Adverse Events** – Adverse events occurring with an incidence of greater than, or equal to, 10% were as follows: **Early therapy:** nausea, dizziness, somnolence, headache, peripheral edema, vomiting, syncope, fatigue and viral infection. **Adjunct therapy:** dyskinesia, nausea, dizziness, somnolence and headache. Dopamine agonists, with an ergoline chemical structure have been associated with adverse experiences such as retroperitoneal fibrosis, erythromelalgia and pulmonary reactions. REQUIP[®] has a novel, non-ergoline chemical structure and no reports of such events have been observed in clinical trials.
Incidence of Adverse Events in Placebo Controlled Trials – The incidence of postural hypotension, an event commonly associated with initiation of dopamine agonist therapy, was not notably different from placebo in clinical trials. However, decreases in systolic blood pressure to < 90 mmHg have been observed in 13% (<65 years), 16% (65 – 75 years) and 7.6% (>75 years) of patients treated with REQUIP[®]. **Table 2** lists adverse events that occurred at an incidence of 1% or more among REQUIP[®]-treated patients who participated in placebo-controlled trials for up to one year. Patients were dosed in a range of 0.75 mg to 24 mg/day. Reported adverse events were classified using a standard World Health Organization (WHO)-based dictionary terminology. The prescriber should be aware that these figures can not be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies can not be compared with figures obtained from other clinical investigations involving different treatments, uses and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse events incidence rate in the population studied.

	TABLE 2 Adverse events with incidence ≥1% from all placebo-controlled early and adjunct therapy studies			
	Early Therapy		Adjunct Therapy	
	REQUIP [®] N = 157 % occurrence	Placebo N = 147 % occurrence	REQUIP [®] N = 208 % occurrence	Placebo N = 120 % occurrence
Autonomic Nervous System				
Sweating Increased	6.4	4.1	7.2	1.7
Mouth Dry	5.1	3.4	5.3	0.8
Flushing	3.2	0.7	1.4	0.8
Body as a Whole General				
Peripheral Edema	13.4	4.1	3.9	2.5
Fatigue	10.8	4.1	–	–
Injury	–	–	10.6	9.2
Pain	7.6	4.1	5.3	3.3
Asthenia	6.4	1.4	–	–
Drug Level Increased	4.5	2.7	6.7	3.3
Chest Pain	3.8	2.0	–	–
Malaise	3.2	0.7	1.4	0.8
Therapeutic Response				
Decreased	1.9	0.7	–	–
Cellulitis	1.3	0.0	–	–
Influenza-like Symptoms	–	–	1.0	0.0
Fever	–	–	1.4	0.0
Cardiovascular General				
Syncope	11.5	1.4	2.9	1.7
Hypotension Postural	6.4	4.8	–	–
Hypertension	4.5	3.4	3.4	3.3
Hypotension	1.9	0.0	2.4	0.8
Cardiac Failure	–	–	1.0	0.0
Central and Peripheral Nervous System				
Dizziness	40.1	21.8	26.0	15.8
Dyskinesia	–	–	33.7	12.5
Headache	17.2	17.0	16.8	11.7
Ataxia (Falls)	–	–	9.6	6.7
Tremor	–	–	6.3	2.5
Paresthesia	–	–	5.3	2.5
Hyperesthesia	3.8	2.0	–	–
Dystonia	–	–	4.3	4.2
Hypokinesia	–	–	5.3	4.2
Paresis	–	–	2.9	0.0
Speech Disorder	–	–	1.0	0.0
Vertigo	1.9	0.0	–	–
Carpal Tunnel Syndrome	1.3	0.7	–	–
Gastrointestinal System				
Nausea	59.9	21.8	29.8	18.3
Vomiting	12.1	6.8	7.2	4.2
Dyspepsia	9.6	4.8	–	–
Constipation	8.3	7.5	5.8	3.3
Abdominal Pain	6.4	2.7	8.7	7.5
Diarrhea	–	–	4.8	2.5
Anorexia	3.8	1.4	–	–
Fatulence	2.5	1.4	1.9	0.8
Tooth Disorder	1.9	0.7	1.0	0.8
Saliva Increased	–	–	2.4	0.8
Colitis	1.3	0.0	–	–
Dysphagia	1.3	0.0	2.4	0.8
Periodontitis	1.3	0.0	1.4	0.8
Eructation	–	–	1.4	0.0
Fecal Incontinence	–	–	1.0	0.0
Hemorrhoids	–	–	1.0	0.0
Gastroesophageal Reflux	–	–	1.0	0.0
Gastrointestinal Disorder (NOS)	–	–	1.0	0.0
Tooth Ache	–	–	1.0	0.0
Hearing and Vestibular				
Tinnitus	1.3	0.0	–	–
Heart Rate and Rhythm				
Palpitation	3.2	2.0	2.9	2.5

	Early Therapy		Adjunct Therapy	
	REQUIP® N = 157 % occurrence	Placebo N = 147 % occurrence	REQUIP® N = 208 % occurrence	Placebo N = 120 % occurrence
Heart Rate and Rhythm				
Extrasystoles	1.9	0.7	–	–
Tachycardia	1.9	0.0	1.0	0.0
Fibrillation Atrial	1.9	0.0	–	–
Tachycardia Supraventricular	1.3	0.0	–	–
Bradycardia	–	–	1.0	0.0
Liver and Biliary System				
Gamma - GT increased	1.3	0.7	1.0	0.0
Hepatic Enzymes Increased	1.3	0.0	–	–
Metabolic and Nutritional				
Alkaline Phosphate increased	2.5	1.4	1.0	0.0
Weight Decrease	–	–	2.4	0.8
Hypoglycemia	1.3	0.0	–	–
Musculoskeletal System				
Arthralgia	–	–	6.7	5.0
Arthritis	–	–	2.9	0.8
Arthritis Aggravated	1.3	0.0	1.4	0.0
Myocardial, Endocardial, Pericardial Valve				
Myocardial Ischemia	1.3	0.7	–	–
Psychiatric				
Somnolence	40.1	6.1	20.2	8.3
Anxiety	–	–	6.3	3.3
Confusion	5.1	1.4	8.7	1.7
Hallucination	5.1	1.4	10.1	4.2
Nervousness	–	–	4.8	2.5
Yawning	3.2	0.0	–	–
Amnesia	2.5	1.4	4.8	0.8
Dreaming Abnormal	–	–	2.9	1.7
Depersonalization	–	–	1.4	0.0
Paranoid Reaction	–	–	1.4	0.0
Agitation	1.3	0.7	1.0	0.0
Concentration Impaired	1.9	0.0	1.0	0.0
Illusion	1.3	0.0	–	–
Thinking Abnormal	–	–	1.4	0.8
Apathy	–	–	1.0	0.0
Increased Libido	–	–	1.0	0.0
Personality Disorder	–	–	1.0	0.0
Red Blood Cell				
Anemia	–	–	2.4	0.0
Reproductive Male				
Impotence	2.5	1.4	–	–
Prostatic Disorder	–	–	1.0	0.0
Penis Disorder	–	–	1.3	0.0
Resistance Mechanism				
Upper Respiratory Tract Infection	–	–	8.7	8.3
Infection Viral	10.8	3.4	7.2	6.7
Respiratory System				
Pharyngitis	6.4	4.1	–	–
Rhinitis	3.8	2.7	–	–
Sinusitis	3.8	2.7	–	–
Dyspnea	3.2	0.0	2.9	1.7
Bronchitis	2.5	1.4	–	–
Respiratory Disorder	1.9	1.4	1.9	0.0
Pneumonia	1.3	0.7	1.0	0.8
Coughing	–	–	1.4	0.8
Skin/Appendages				
Pruritis	–	–	1.0	0.0
Urinary System				
Urinary Tract Infection	5.1	4.1	6.3	2.5
Cystitis	1.3	0.7	–	–
Micturition Frequency	–	–	1.4	0.0
Pyuria	–	–	1.9	0.8
Urinary Incontinence	–	–	1.9	0.8
Urinary Retention	1.3	0.7	–	–
Dysuria	–	–	1.0	0.0
Vascular Extracardiac				
Peripheral Ischemia	2.5	0.0	–	–
Vision				
Vision Abnormal	5.7	3.4	–	–
Eye Abnormality	3.2	1.4	–	–
Diplopia	–	–	1.9	0.8
Xerophthalmia	1.9	0.0	1.4	0.8
Cataract	–	–	1.4	0.8
Lacrimation Abnormal	–	–	1.4	0.0
White Cell and Reticuloendothelial System				
Eosinophilia	–	–	1.4	0.0

a: Incidence of adverse event <1%.

Post-Marketing Experience - Patients treated with REQUIP® have rarely reported suddenly falling asleep while engaged in activities of daily living, including operation of motor vehicles which has sometimes resulted in accidents (see WARNINGS).

DOSAGE AND ADMINISTRATION: REQUIP® (ropinirole hydrochloride) should be taken three times daily. While administration of REQUIP® with meals may improve gastrointestinal tolerance, REQUIP® may be taken with or without food. The recommended starting dosage is 0.25 mg three times daily. Based on individual patient response, dosage should then be titrated by weekly increments of 0.25 mg per dose as described in the table below. After week 4, daily dosage may be increased by 0.5 to 1.0 mg per dose on a weekly basis until an optimal therapeutic response is established. Smaller dose increments are recommended for patients who may be at risk for orthostatic symptoms.

	Week			
	1	2	3	4
Unit Dose (mg)	0.25	0.5	0.75	1.0
Total Daily Dose (mg)	0.75	1.5	2.25	3.0

In clinical trials, initial benefits were observed with 3 mg/day and higher doses. Doses greater than 24 mg/day have not been included in clinical trials. In a 5-year, double-blind study of early therapy in Parkinson's disease patients, the average daily dose of REQUIP® (based on the observed data set) was 10.1 mg at 6 months (median dose = 9.0 mg), 14.4 mg at 3 years (median dose = 15.0 mg), and 16.6 mg at 5 years (median dose = 18.0 mg), regardless of levodopa supplementation. When REQUIP® is administered as adjunct therapy to levodopa, the dose of levodopa may be decreased gradually as tolerated once a therapeutic effect with REQUIP® has been observed. REQUIP® should be

discontinued gradually over a 7-day period. The frequency of administration should be reduced from three times daily to twice daily for 4 days. For the remaining 3 days, the frequency should be reduced to once daily prior to complete withdrawal of REQUIP®. **Renal and Hepatic Impairment:** In patients with mild to moderate renal impairment, REQUIP® may be titrated in the recommended manner according to clinical response. Patients with severe renal impairment or on hemodialysis have not been studied and administration of REQUIP® to such patients is not recommended. Patients with hepatic impairment have not been studied and administration of REQUIP® to such patients is not recommended. **Estrogen Replacement Therapy:** In patients already receiving estrogen replacement therapy, REQUIP® may be titrated in the recommended manner according to clinical response. However, if estrogen replacement therapy is stopped or started during treatment with REQUIP®, adjustment of the REQUIP® dosage may be required. **AVAILABILITY OF DOSAGE FORM:** REQUIP® is supplied as a pentagonal film-coated Titab® tablet with beveled edges containing ropinirole (as ropinirole hydrochloride) as follows: 0.25 mg - white imprinted with SB and 4890; 1.0 mg - green imprinted with SB and 4892; 2.0 mg - pale pink imprinted with SB and 4893; 5.0 mg - blue tablets imprinted with SB and 4894. REQUIP® is available in bottles in the pack size of 100 tablets. Full Product Monograph available to practitioners upon request.

GlaxoSmithKline Inc.
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LSN 6L4

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Neurologist

A full time Neurologist is required by the Cape Breton District Health Authority to work within a busy community practice setting. The successful candidate will also be part of our dedicated health care team.



The District serves approximately 140,000 people through acute care, continuing care, Mental Health Services, Addiction Services, Public Health Services and the Cape Breton Cancer Centre. Health care professionals, including medical specialists, are attracted to Cape Breton Island because of the variety and scope of health services, the unique lifestyle, natural beauty and rich cultural identity.

All candidates must be certified by the Royal College of physicians and Surgeons and be eligible for licensure in the province of Nova Scotia.

Inquiries and applications may be directed to:

Dr. M.A. Naqvi, Medical Director
Cape Breton District Health Authority
1482 George Street
Sydney, Nova Scotia, Canada
B1P 1P3
Fax: (902) 567-7921
E-mail: naqvim@cbdha.nshealth.ca
Website: www.cbdha.nshealth.ca



Are you a Canadian neurologist, neurosurgeon or neurology/neurosurgery resident?

Then the Canadian Congress of Neurological Sciences (CCNS) has a member society for you!

- **Canadian Journal of Neurological Sciences (CJNS) subscription**, both print and online. CJNS is a highly respected international neurological sciences medical journal.
- **Reduced registration fees** for the annual scientific meeting, depending on membership category.
- The **Annual Membership Directory**, a handy reference tool
- **Maintenance of Certification** and **Continuing Medical Education (CME)** opportunities through the annual meeting.
- The CCNS newsletter **Neuro News**
- **Access to grants, awards and fellowships** (some are restricted to members)
- **Residents and Fellows** receive these benefits for a bargain-priced annual fee of \$35.

The four member societies are:

- ◆ Canadian Neurological Society (CNS)
- ◆ Canadian Neurosurgical Society (CNSS)
- ◆ Canadian Society of Clinical Neurophysiologists (CSCN)
- ◆ Canadian Association of Child Neurology (CACN)

For membership information,
call us at (403) 229-9544;
e-mail: brains@ccns.org
or check out the CCNS website
at www.ccns.org



Fellowship in Stereotactic
& Functional Neurosurgery



The Division of Neurosurgery at Dalhousie University is offering a one year Clinical Fellowship in Stereotactic & Functional Neurosurgery. Functional neurosurgical procedures for Atlantic Canada (population 2,500,000) are performed at the QEII Health Sciences Center/Dalhousie University. The Division of Neurosurgery is affiliated with the multimillion dollar Brain Repair Centre, with facilities ranging from basic science laboratories to a human 4T MRI. Fellows will participate in the evaluation and treatment of patients with a broad range of functional neurosurgical disorders including:

- Movement disorders
- Complex pain
- Epilepsy
- Spasticity
- Angina

Fellows will have training in different techniques including:

- Deep brain stimulation, with and without microelectrode recording
- Motor Cortex Stimulation
- Spinal cord stimulation
- Intrathecal therapy
- Ablative procedures
- Selective mesial temporal resections
- Extratemporal resections for epilepsy
- Neurotransplantation
- Vagus nerve stimulation

Fellows are expected to be involved in clinical research projects. Opportunities for those interested in basic science research are also available. Candidates must have completed their neurosurgical training and be eligible for licensure in Nova Scotia. This position is to commence July 01, 2007. Interested candidates should send three letters of reference along with their cover letter outlining why they wish to study stereotactic and functional neurosurgery, by date February 28, 2006. To

Rob Brownstone, MD, PhD, FRCS
Division of Neurosurgery, QEII Health Sciences Center
3816-1796 Summer Street, Halifax, NS B3H3A7
Phone: (902)473-6850 Fax: (902) 473-6852
Email: rob.brownstone@dal.ca

Websites: www.neurosurgery.medicine.dal.ca
www.brainrepair.ca
www.neuraltransplantation.dal.ca
www.motorcontrol.med.dal.ca



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NEUROLOGISTS - Wisconsin

Marshfield Clinic Neurosciences Division includes 25 neurologists, 6 neurosurgeons, 3 neuroradiologists and 3 neuropsychologists. Clinical subspecialties are represented in cerebrovascular disease, epilepsy, sleep, dementia, movement disorders, neuromuscular disease, pediatric neurology and neuroimmunology. Research opportunities abound but are not prerequisite. The work atmosphere supports sub-specialty practice development, collaborative effort and quality care.

We have the following practice opportunity available for a BC/BE Neurologist at our Marshfield Center in Marshfield, Wisconsin:

- Epilepsy Neurologist

We are also seeking one BC/BE Neurologist, with or without fellowship training, for our Wausau/Weston Centers (state-of-the-art Weston Center opened in October 2005)

We offer a generous salary and excellent compensation package including: Malpractice, health, dental, life and disability insurance, \$5,500 Education Allowance with 10 days of CME time; generous employer contributed retirement and 401K plan; four weeks vacation 1st year; up to \$10,000 relocation allowance, and more.

Marshfield Clinic is a physician directed organization with over 700 physicians practicing in over 80 medical specialties and subspecialties. There are over 40 regional centers serving north central and western Wisconsin. The main campus includes a tertiary clinical center, research center and 504-bed tertiary hospital. The work atmosphere is academic, collegial and informal. Send your curriculum vitae in confidence, to: **Sandy Heeg, Physician Recruiter, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, Wisconsin 54449. Phone: (800) 782-8581 extension 19781. Fax #: (715) 221-9779. E-mail: heeg.sandra@marshfieldclinic.org Visit our website for more information www.marshfieldclinic.org/recruit**



MARSHFIELD CLINIC.

Where the future of medicine lives

Marshfield Clinic is an Affirmative Action/Equal Opportunity employer that values diversity. Minorities, females, individuals with disabilities and veterans are encouraged to apply. Sorry, not a health professional, storage area.

Neurologist

Saskatoon
(Health
Region)



Applications are invited for an Academic Neurologist staff position in the Department of Medicine, University of Saskatchewan, Saskatoon. Neurology is very actively involved in undergraduate teaching and has a fully accredited Royal College program for Neurology Residency training. There is extensive interaction with paediatric neurologists, neuroradiologists, neuropathologists, and neurosurgeons. The successful applicant will hold Canadian certification or eligibility for examination. Licensure with the College of Physicians and Surgeons of Saskatchewan is necessary.

To Apply:

Please direct inquiries and applications to:

Jackie McKee
Medical Affairs
Saskatoon Health Region
Saskatoon City Hospital
2nd Floor, Administration
701 Queen Street
Saskatoon, Saskatchewan S7K 0M7
Phone: (306) 655-7948, Fax: (306) 655-7961
E-mail: jackie.mckee@saskatoonhealthregion.ca

Optimize Dosing... To Help Maximize Outcomes In Parkinson's Therapy¹



Titrate to help maximize patient benefit. In at least 75% of the patients who responded to REQUIP®, doses of up to 9 mg/day were necessary to ensure a first therapeutic response.^{1}*

Three Reasons to Prescribe REQUIP®

REQUIP® delayed the use of L-dopa

34% (n=29 of 85) of REQUIP® monotherapy patients completed the entire 5-year study without requiring L-dopa supplementation^{2†}

Low risk of dyskinesia

Only 5% of REQUIP® monotherapy patients developed dyskinesia compared with 36% of L-dopa patients^{2}*

Low supplementary dose of L-dopa needed

When used with adjunct L-dopa, REQUIP® patients required an average of 43% less L-dopa (427 ± 221 mg) than patients on L-dopa alone (753 ± 398 mg)²

¹ In early treatment of Parkinson's disease over the course of a 5-year multicentre, prospective, double-blind, flexible-dose study, with 268 patients randomized to either REQUIP® (n=179) or L-dopa and benserazide (a decarboxylase inhibitor) (n=89). Open label L-dopa was available as supplementary medication.^{2,3} p<0.001

* Prior to supplementation with L-dopa

² Data from 3 large phase III double-blind trials of ropinirole monotherapy in early Parkinson's disease were examined: a 5-year L-dopa-controlled trial (n=179), a 3-year bromocriptine-controlled trial (n=168), both with planned interim analysis and a 6-month placebo-controlled trial (n=116).¹

³ Please consult the Warnings section of the Product Monograph.³

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References: 1. Korczyn AD *et al.* Dosing with ropinirole in a clinical setting. *Acta Neurologica Scandinavica* 2002;106:200-204. 2. Rascol O *et al.* A five-year study of the incidence of dyskinesia in patients with early Parkinson's disease who were treated with ropinirole or levodopa. *N Eng J Med* 2000;342(20):1484-1491. 3. Product Monograph of REQUIP® (ropinirole hydrochloride), GlaxoSmithKline, March 2004.

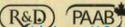
REQUIP® (ropinirole hydrochloride) is indicated in the treatment of the signs and symptoms of idiopathic Parkinson's disease. REQUIP® can be used both as early therapy, without concomitant levodopa and as an adjunct to levodopa. Patients receiving treatment with REQUIP® and other dopaminergic agents have reported the sudden onset of sleep while engaged in daily activities. Patients should be warned not to drive or engage in other activities where impaired alertness could put themselves or others at risk.^{3†}

Adverse events occurring with an incidence of greater than, or equal to, 10% were as follows: *Early therapy:* nausea, dizziness, somnolence, headache, peripheral edema, vomiting, syncope, fatigue and viral infection. *Adjunct therapy:* dyskinesia, nausea, dizziness, somnolence and headache. REQUIP® is contraindicated in patients with a known hypersensitivity to ropinirole hydrochloride or the excipients of the drug product.³

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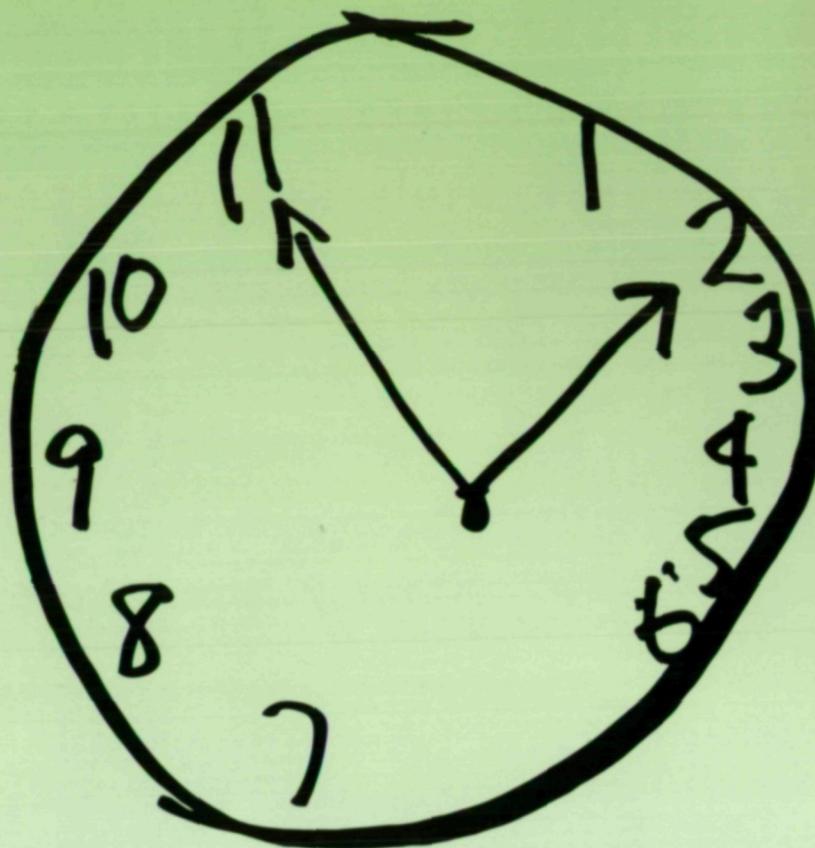


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For brief prescribing information see pages A-18, A-19

NEW
Once-a-Day
REMINYL ER



It's Time To Take Another Look at REMINYL.

REMINYL is now available in a once-a-day formulation: REMINYL ER.¹
Consider new REMINYL ER as initial treatment in AD.

REMINYL ER (galantamine hydrobromide) is indicated for the symptomatic treatment of patients with mild to moderate dementia of the Alzheimer's type. REMINYL ER has not been studied in controlled clinical trials for longer than 6 months.

The most common side effects (vs. placebo) in a clinical trial were nausea (17% vs. 5%), dizziness

(10% vs. 4%), injury (8% vs. 6%) and headache (8% vs. 6%). For patients who experienced adverse events, the majority occurred during the dose-escalation phase.

There is no evidence that galantamine alters the course of the underlying dementing process.

REFERENCE: 1. REMINYL[®] (galantamine hydrobromide tablets), REMINYL[®] ER (galantamine hydrobromide extended-release capsules) Product Monograph, JANSSEN-ORTHO Inc., April 8, 2005.

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For brief prescribing information see page A-15